HIV/AIDS IN ASIA

HEARING

BEFORE THE

SUBCOMMITTEE ON ASIA AND THE PACIFIC

OF THE

COMMITTEE ON INTERNATIONAL RELATIONS HOUSE OF REPRESENTATIVES

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HIV/AIDS IN ASIA

WEDNESDAY, JULY 21, 2004

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON ASIA AND THE PACIFIC,
COMMITTEE ON INTERNATIONAL RELATIONS,
Washington, DC.

The Subcommittee met, pursuant to call, at 1:38 p.m. in Room 2172, Rayburn House Office Building, Hon. James A. Leach presiding.

Mr. LEACH. The Subcommittee will come to order.

On behalf of the Subcommittee, I would like to welcome our distinguished witnesses. We appreciate your participation and look forward to your assessment of the scope of the AIDS problem.

Parenthetically, I would like to note how pleased we are that the Chinese authorities have decided to release the well-known surgeon, Dr. Jiang Yanyong. Dr. Jiang became a national hero in China last year for his efforts to expose the cover-up of the scope of the SARS epidemic. Subsequently, Dr. Jiang was taken into custody for his appeal to China's leaders for reappraisal of the tragic events that surrounded the Tienenman Square event of 1989.

I understand that Dr. Jiang has indicated he now focuses his efforts on combating HIV/AIDS. And we wish him the best in this important endeavor.

Turning to the subject of our hearing, it is self-apparent that I think the biggest challenge of our era and the biggest foreign policy of our times is the AIDS issue. And on the plus side, our Government has provided more assistance than all other governments combined in the world. On the minus side, we are probably doing about a tenth of what we should be doing.

The stark reality is that the world today is confronted with the greatest health crisis in history. The latest figures released by UNAIDS show that approximately 40 million people are living with HIV/AIDS in 2003, including 2.5 million children under the age of 15. World-wide, there are an astounding 14,000 new infections daily, with more than 95 percent in the developing world.

Perspective is always hard to apply to events of the day. For example, if one were living in the 14th century, one would be hard-pressed not to conclude that the most important event of that time was the bubonic plague, in which 20 million people died. That figure was reached several years ago with regard to AIDS, and within the decade the toll could be a multiple of this amount. So the AIDS epidemic is extraordinary, and it is destabilizing entire societies, and represents a formidable challenge to those it has not completely destabilized.

As highlighted last week by the 15th International AIDS Conference in Bangkok, several countries in Asia and the Pacific are at a critical point in their efforts to curb the spread of the virus. The virus is devastating some high-risk groups and making inroads into the general population. So far, however, the epidemic has not exploded in Asia to the degree it has in sub-Saharan Africa. To date, about 20 percent of those living with HIV/AIDS live in Asia, while one in four new HIV infections in the world has also occurred in that region.

Based on these trends, some experts believe that Asia will have more people with HIV in 2010 than the roughly 30 million in sub-Saharan Africa today.

At this juncture, however, the scale of Asia's epidemic would appear to have more to do with the size of the region's population than the spread of the virus itself. No Asian country has reported a prevalence rate higher than 4 percent, and a relative few prenatal clinics have found infection rates above 1 percent, the standard measure for a generalized epidemic. By contrast, half a dozen African countries now have adult prevalence rates of 10 percent or more.

But even if Asia avoids the high infection rates of Africa, health experts stress that a low prevalence rate in just one country, such as China or India, could spell disaster and have major ripple effects through the region and the world economy.

Meanwhile, Burma, Thailand, and Cambodia have the highest rates of infection anywhere outside Africa. In this circumstance, complacency is not an option.

It is clear the U.S. is compelling national interest in working with others to help stem the spread of the disease and care for victims of it. Infectious diseases know no borders. Millions of Americans travel and live abroad; many in this country live with this disease in their own families.

The opportunity to do something about this scourge offers a fortunate coincidence of self-interest and moral imperative. Out of a sense of self-preservation, I thought simply a humanitarian concern for those affected, this disease has to be eradicated, whatever the cost.

[The prepared statement of Mr. Leach follows:]

PREPARED STATEMENT OF THE HONORABLE JAMES A. LEACH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF IOWA, AND CHAIRMAN, SUBCOMMITTEE ON ASIA AND THE PACIFIC

On behalf of the Subcommittee, I would like to welcome our distinguished witnesses to today's hearing on the challenge of HIV/AIDS in Asia. We appreciate your participation and look forward to your assessment of the scope of the problem as well as prospects for comprehensive prevention and treatment of the disease throughout the region.

Parenthetically, I would like to note how pleased we are that the Chinese authorities have decided to release the well-known surgeon Dr. Jiang Yanyong. Dr. Jiang became a national hero in China last year for his efforts to expose a cover-up of the true scope of the SARS epidemic by authorities in Beijing. Subsequently, Dr. Jiang was taken into custody for his appeal to China's leaders for a reappraisal of the tragic events in Tiananmen Square during June 1989. I understand that Dr. Jiang has indicated he will now focus his efforts on combating HIV/AIDS. We wish him all the best in this important endeavor.

Turning to the subject of our hearing, AIDS is the biggest public challenge and foreign policy issue of our time. On the plus side, on a bipartisan and bi-institu-

tional basis the U.S. government has provided more than one half of AIDS assistance to the world; on the minus side, it is probably one tenth of what is necessary.

The stark reality is that the world today is confronted with the greatest health crisis in human history. The latest figures released by UNAIDS show that approximately 40 million people were living with HIV/AIDS in 2003, including two and a half million children under the age of fifteen. Worldwide, there are an astounding 14,000 new infections daily, with more than 95% in the developing world.

Perspective is always hard to apply to events of the day. For example, if one was to look at the 14th century, one would be hard pressed not to conclude that the most important event of that time was the bubonic plague during which 20 million died. With regard to AIDS that awesome death number was reached several years ago, and within a decade, the toll could be a multiple of that figure. In a circumstance in which the HIV/AIDS pandemic is destabilizing entire societies, it is self-evident that discovering techniques to eradicate this deadly disease is the most important health science challenge ever.

As highlighted by the 15th international AIDS conference in Bangkok last week, several countries in Asia and the Pacific are at a critical point in their efforts to curb the spread of HIV. The virus is devastating high-risk groups and making inroads into the general population. To date, about 20% of those living with HIV/AIDS live in Asia, while one in four new HIV infections in the world in 2003 occurred in the region.

Based on these trends, experts believe that Asia will have more people with HIV in 2010 than the roughly 30 million in sub-Saharan Africa today. While the scale of Asia's epidemic is not as great as Africa's, the virus is just beginning to take hold. Today, no Asian country has reported a prevalence rate higher than 4%, and relatively few prenatal clinics have found infection rates above 1%—the standard measure for a generalized epidemic. By contrast, half a dozen African countries now have adult prevalence rates of 10% or more; nevertheless, without a massive public commitment to education and prevention in Asia, comparable problems could occur.

Even if Asia avoids high infection rates, however, health experts stress that a low prevalence rate in a large country—such as China or India—can spell disaster and have major ripple effects through the region. Meanwhile, Burma, Thailand, and Cambodia have the highest rates of HIV infection anywhere outside Africa. In this circumstance, complacency is not an option.

It is clear that the U.S. has a compelling national interest in working with others to help stem the spread of HIV/AIDS and care for the victims of this dread disease. Infections diseases, like HIV/AIDS, know no borders. Millions of Americans travel and live abroad. Many in this country live with this disease in their own families. The opportunity to do something about this deadly scourge offers a coincidence of self-interest and moral imperative. Out of a sense of self-preservation for mankind itself, if not simply a humanitarian concern for those currently affected, this disease must be eradicated, whatever the cost.

Mr. LEACH. Jerry, do you want to make an opening statement?

Mr. FALEOMAVAEGA. Thank you, Mr. Chairman. I certainly want to commend you for your leadership, and for holding this hearing on the HIV/AIDS in the Asia-Pacific region.

I also want to welcome my witnesses, and thank my good friend Sanjay Puri for his leadership on this very important issue, and on behalf of our Indian-American community.

I am particularly pleased that Dr. Vijay Yeldandi, a leading expert on HIV/AIDS in India, will be one of our experts testifying on the panel this afternoon.

Mr. Chairman, traditionally age has always been associated with Continental Africa. Ironic that the latest meeting that was held, international Conference that was held on AIDS was held in Asia. And I think it gives it a very striking need, not only for the national media, but for people around the world, that it is just as important and critical in tracking this issue in the Asia-Pacific region.

To date, almost two-thirds of all HIV-positive Asians live in India. India reports 1,000 new AIDS cases per month, and it has the second-largest population of people living with HIV/AIDS in the world, with between 2.5 and 8.5 million people infected. By 2005,

it is believed that India will hold the largest population of people infected with the virus.

Many experts are particularly concerned about India because infections are starting to move from high-risk groups to the general population. Government spending on HIV/AIDS also remains relatively low, and U.S. assistance has been minimal. Like many of my colleagues, I was shocked when President Bush announced that Vietnam would become the 15th country under the President's Emergency Plan for AIDS Relief.

While I support Vietnam, Vietnam has a prevalence rate of less than 1 percent, a lower HIV prevalence than the United States. Burma has one of the worst HIV/AIDS problems in Asia. Cambodia has the second-highest HIV rate. One researcher predicts that West Papua, New Guinea may look like Africa in 5 years.

And even if Asia holds high prevalence rates, health experts stress that a low prevalence rate in a large country such as India can spell disaster, and have major rippling effects throughout the region, and even throughout the world.

I want to thank the Gates Foundation for making a number of grants to India. It is my understanding the Gates Foundation intends to spend a total of $200 million to help combat HIV/AIDS in India, and that the World Bank has loaned India $191 million to implement its HIV/AIDS programs.

Mr. Chairman, I am also hopeful that the U.S. will now do its part, our country will do our part. And I look forward to working with you and other Members of this Committee in drafting appropriate legislation to curb the spreading of HIV/AIDS in the Asia-Pacific region.

I also want to offer my personal welcome to the members of the panel, Dr. Cravero, Dr. Gill, and Ms. Burkhalter, for their testimony. I look forward to hearing from them.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Faleomavaega follows:]

PREPARED STATEMENT OF THE HONORABLE ENI F.H. FALEOMAVAEGA, A REPRESENTATIVE IN CONGRESS FROM AMERICAN SAMOA

Mr. Chairman:

I want to commend you for your leadership and for holding this hearing on HIV/AIDS in Asia. I also want to welcome our witnesses and thank my good friend Sanjay Puri for his leadership on HIV/AIDS on behalf of the Indian American community. I am particularly pleased that Dr. Vijay Yeldandi, a leading expert on HIV/AIDS in India, will be testifying.

To date, almost two-thirds of all HIV-positive Asians live in India. India reports 1,000 new AIDS cases per month and it has the second largest population of people living with HIV/AIDS in the world with between 2.5 and 8.5 million people infected. By 2005, it is believed that India will hold the largest population of people infected with the virus.

Many experts are particularly concerned about India because infections are starting to move from high risk groups to the general population. Government spending on HIV/AIDS also remains relatively low and U.S. assistance has been minimal.

Like many of my colleagues, I was shocked when President Bush announced that Vietnam would become the 15th country under the President's Emergency Plan for AIDS Relief (PEPFAR). While I support Vietnam, Vietnam has a prevalence rate of less than 1%, a lower HIV prevalence than the United States.

Burma has one of the worst HIV/AIDS problems in Asia. Cambodia has the second highest HIV rate. One researcher predicts that West Papua may look like Africa in five years.

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Mr. Chairman, I am also hopeful that the U.S. will now do its part and I look forward to working with you and members of this Committee in drafting and implementing legislation to curb the spread of HIV in Asia

Mr. BLUMENAUER. Mr. Chairman, I just wanted to say that I thought your comments were right on the money. We are doing more. It is not enough. And I am looking forward to the presentation of the panel. I think it is an important follow-up to the Conference.

I would hope that if there is one thing that our Committee could do, with the help of the distinguished panel, is that we could get across the notion that we have made this important 5-year commitment; it has bipartisan support.

If there is anything that we do around here that could not be back-loaded—we have made the commitment, I am convinced we are going to keep it—but this is one of the areas where we should accelerate the funding to meet this critical funding gap and inspire our neighbors, our friends, our allies, and our important partners in the private sector.

And I hope that that is one thing that we can work on together. It will not destroy our 5-year budget projections. It is clearly within our capacity. And the consequences will be the saving of millions of lives.

Mr. LEACH. Thank you very much. At this point let me introduce our panel.

Kathleen Cravero is the Deputy Executive Director of the Joint United Nations Program on HIV/AIDS.

Dr. Bates Gill is the Freeman Chair in China Studies at the Center for Strategic and International Studies.

Dr. Vijay V. Yeldandi is the Director of Clinical Research at the Metro Foundation.

And Ms. Holly Burkhalter is the U.S. Policy Director for Physicians for Human Rights, here in their Washington office.

So welcome to all of you.

Unless there is a prearrangement that would do it differently, I will just introduce you in the manner in which you have been presented.

Let me say all of your statements, without objection, will be placed in the record. And you may proceed and summarize as you see fit.

I would, if possible, like to hold you to 5 to 8 minutes. But let me proceed as informally as we can.

Dr. Cravero.

STATEMENT OF KATHLEEN CRAVERO, PH.D., DEPUTY EXECUTIVE DIRECTOR, JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS [UNAIDS]

Ms. CRAVERO. Thank you, Mr. Chairman. Distinguished Members of the Subcommittee, ladies and gentlemen, I thank you for the opportunity to testify before you this afternoon. I commend you

for your longstanding leadership in the global fight against AIDS, and for now turning the attention of the Subcommittee and the Congress to the AIDS epidemic in Asia and the Pacific.

This Committee shined a bright light on the burgeoning AIDS epidemic in Africa, and drove the enactment of the U.S. Leadership Against AIDS Act of 2003.

I am confident that your focus on Asia will ultimately lead to much-needed action against AIDS in this region, as well. And for that, we thank you.

As you know, the 15th International AIDS Conference took place in Bangkok last week. This Conference was intended as a wake-up call for Asia, and by all indications, it may be just that.

The AIDS Conference in South Africa was a watershed moment for expanded access to treatment. We hope that the Thailand Conference will be remembered as the moment we collectively faced the challenge of AIDS in Asia.

First, the facts. There is little doubt that in the fight against AIDS, we once again stand at a crossroads. Asia is now at the center of this gathering storm.

Let us recap just a few of the facts that UNAIDS released last week.

Mr. Chairman, as you have indicated, Asia now accounts for nearly 7.5 million people living with HIV. Last year alone, half a million people died from AIDS, and more than twice as many were infected with HIV, one in four of all new infections world-wide.

Asia is now home to some of the fastest-growing AIDS epidemics in the world, primarily due to sharp increases in China, Indonesia, and Vietnam.

In the Pacific, the HIV prevalence rate has reached 1 percent among women attending ante-natal clinics in Port Moresby, Papua New Guinea. High levels of sexually-transmitted infections, which indicate increased risk for HIV, have also been documented in Samoa. And as we have seen in the Caribbean, even a small number of infections can have a dramatic impact on small island populations.

Although the national HIV prevalence rate in China and India is low—0.1 percent in China, and between 0.4 and 1.3 percent in India—both have extremely serious epidemics in a number of provinces, territories, and states.

And let us keep in mind that because the region accounts for 60 percent of the world's population, even relatively low HIV prevalence translates into millions of lives. While less than 1 percent of adults in India are HIV-infected, this is about 5 million people, more than the entire populations of Botswana, Namibia, and Swaziland combined.

In most places in the region, HIV remains largely concentrated among marginalized groups, such as injecting drug users, men who have sex with men, sex workers, and their clients and partners. But infection rates among these groups are skyrocketing, and ultimately will not remain contained.

Monogamous women, whose only high-risk behavior is being married and faithful to spouses who engage in high-risk behavior, are being infected, and then, sadly, infecting their children. This is how a generalized epidemic begins.

Timing matters, and Asia has a narrow window of opportunity. As we have seen, HIV levels can remain relatively low for many years, and then explode quite rapidly. Just look at what happened in South Africa. It took 5 years for the prevalence rate to rise from 0.5 to 1 percent, but then shot to 20 percent over the next 7 years, in the absence of prevention.

While we do not expect something quite this dramatic in Asia, it is vital to act decisively before hitting this tipping point. One thing is for certain: What happens in Asia will set the tone for the future of the epidemic globally.

Asia is an investment opportunity. We should act now, or we will pay later.

As you know, Asia is a region which has made great economic progress, and is now seriously threatened by AIDS. A joint study by UNAIDS and the Asian Development Bank estimates that economic losses due to AIDS were more than $7 billion in 2001 alone, borne overwhelmingly by AIDS-affected households. This has impoverished millions of men, women, and children.

The region, and all of us, now have clear choices to make, with equally clear consequences. If the current trends continue and we fail to take comprehensive action in Asia, a total of 10 million adults and children will likely become infected in the region between now and 2010. The annual death toll will increase by 50 percent, to over three-quarters of a million people by 2010, and economic losses will more than double, amounting to $17 million annually by 2010.

The good news is that we know what works. "ABC plus" works. Harm reduction programs work. Voluntary counselling and testing programs, especially those accompanied by treatment, work. Interventions to stop mother-to-child transmission work. Treating STDs works. Ensuring a safe blood supply and safe health care settings works. Micro-finance and other empowerment programs for women, and fighting stigma, fear, and discrimination while promoting hope works.

The problem is in Asia, as in Africa, only a small fraction of those in need are currently receiving these lifesaving services. Increasing access to AIDS prevention and treatment will require a serious investment. Last year, $1.5 billion was needed for a comprehensive response to AIDS in Asia, yet only $200 million was spent by all public sources combined.

This resource gap will continue to grow as unmet needs grow. And by 2007, the funding needed for AIDS prevention and treatment services in Asia will rise to $5.1 billion annually, or approximately $2.00 per capita.

If the necessary leadership and resources are found from governments in the region and from donor support, and comprehensive programs are implemented, we can change the course of this epidemic, and perhaps the course of history. We can prevent six million new infections by 2010. We can reduce the death toll by nearly 100,000 people each year. We can save $2 billion in economic losses in each year, from 2010. And we can alleviate unquantifiable human suffering in Asia alone.

What is the role of the United States? The U.S. has long been a global leader in the fight against AIDS, and is now the world's

largest provider of global AIDS funding. To date, the U.S. global AIDS initiatives primary focus on 14 African and Caribbean countries has provided much-needed assistance to the two regions most heavily impacted by AIDS. We are grateful for this attention.

However, as the epidemic expands around the globe, it is increasingly urgent that we accelerate concerted action on AIDS in Asia.

The recent selection of Vietnam as the 15th United States focus country is an important step, and UNAIDS was pleased to have the chance to brief Ambassador Tobias on his recent trip to Vietnam. However, we must view this as a first step toward a comprehensive response to AIDS in Asia.

Because overall HIV prevalence rates remain low in the Asia-Pacific region, the sense of urgency for action has yet to reach a fever pitch. However, the numbers do not lie, and AIDS in Asia is fast approaching a critical tipping point.

The United States has much to offer as a key strategic partner, through a three-pronged approach to helping to ratchet up the Asian response to AIDS.

Firstly, by promoting leadership through diplomacy. This includes encouraging Asian leaders to participate actively in international political fora, and to put AIDS on the agenda of regional institutions, such as ASEAN and APEC. The UNAIDS-supported Asia-Pacific Leadership Forum on HIV/AIDS and Development is designed to do just that.

At national level, U.S. Ambassadors to Asia have a critical role to play, as they have in Africa through the new United States initiative.

Secondly, investing and leveraging real resources for what works. The U.S. should also invest in what works, and urge others, including impacted countries, to do the same. This includes "ABC plus," a model that builds on the foundation of abstinence, fidelity, and condom use, to promote female-controlled prevention methods, including female condoms and microbicides, and empowering women and engaging men.

The fact is that women struggling to get through the day without suffering violence are not in a position to negotiate anything, let alone abstinence or condoms. That is what I heard from women leaders in the Mekong Region when they launched their coalition on women and AIDS, and that is what I have heard from women all over the world.

Thirdly, sharing expertise and building capacity. In Asia, as elsewhere, there is a desperate need for capacity building, especially within the health sector; for technical assistance and program implementation and management; and for the training of doctors, nurses, and community workers needed to scale up treatment and prevention services.

Asian countries also need help to monitor and evaluate both the scope and scale of the epidemic, and the value of ongoing interventions. The U.S. could help in this effort.

Overall, the United States has a central role to play in the Asia-Pacific region. Increased investments in AIDS in Asia by the United States and other donors now will help avert millions of new HIV infections and AIDS deaths, and ensure national and regional security, better governance, and sustained economic growth.

UNAIDS is ready and able to make a difference. We know that business as usual will not stop AIDS. That is why the Joint United Nations Programme on HIV/AIDS, or UNAIDS, was created.

Today, through the leadership of UNAIDS, 10 U.N. agencies and a Secretariat have joined forces in concerted action against AIDS worldwide. In reality, UNAIDS is U.N. reform in action.

Working globally, regionally, and on the ground in more than 65 countries, UNAIDS is helping to develop the leadership, build the capacity, and apply the expertise needed for a more effective response to AIDS. UNAIDS is focused not on mobilizing resources alone, but on maximizing their effectiveness on the ground, where the rubber meets the road.

In Asia and the Pacific, UNAIDS has been key to galvanizing political leadership and commitment. For example, in India, where UNAIDS directly supported the creation of the Indian Parliamentarian Forum on AIDS, and nurtured its growth from a gathering of 15 Parliamentarians in 2000 to a convention of 1,500 in 2003.

In China, where UNAIDS has been key to promoting awareness at the highest levels of government and developing a "Joint Assessment of HIV/AIDS Prevention, Treatment, and Care."

In Fiji, where we have helped the President of Fiji and the Chair of the Great Council of Chiefs commit themselves to action against AIDS, and call on all sectors to do their part.

And at the Asia Regional level, UNAIDS supported the Association of the Southeast Asian Nations in convening a special summit on AIDS, and is now supporting implementation of their work plan.

UNAIDS is also enlisting key partners throughout the region, where it is considered a neutral broker and a trusted facilitator. It helped mobilize business coalitions, unions, youth and women's organizations, religious groups, police and military personnel, and sports organizations, including cricket councils across the region, just to name a few.

It has helped to develop and disseminate strategic information, including access to user-friendly policies and best-practice information. It has helped mobilize and maximize resources. In 2003, UNAIDS provided technical assistance in the development of global fund proposals in 13 countries, and assisted other resource mobilization activities in 12 more. Countries receiving UNAIDS support were over four times more likely to be funded than those who did not.

And most recently, UNAIDS has spearheaded, in cooperation with the U.S. Government and others, the adoption of three key principles to guide donor support for AIDS. Known as the "three-ones," these principles help to ensure that our action at country level is country-driven, and that whatever our respective role, we all agree to work with: One AIDS action plan that provides the basis for coordinating the work of all partners; one national AIDS coordinating authority, with a multi-sectoral mandate that involves all key players; and one monitoring and evaluation system for tracking progress toward results.

We have a long way to go, but the "three-ones" gives us a much-needed roadmap. The true test will come in the application of these principles, country-by-country, and in our ability to translate this

opportunity into prevention, treatment, and support services for the millions in need.

UNAIDS has been charged with moving this process forward, and this responsibility is a high priority for us. We look forward to working closely with the U.S., and are very pleased that the House Foreign Operations Appropriations Bill has requested a quick report on progress in this effort.

In conclusion, Mr. Chairman, we are at a critical juncture in the global fight against AIDS, and the stakes are high, for Asia and for us all. Success will require more money, more action, and most of all it will require unprecedented coordination, and a framework for moving forward together, particularly at country level.

We have the skill and the science to stop AIDS. What we need now is the political will, the strategy, and the unity to turn the tide. It is not about PEPFAR versus the Global Fund. It is not about prevention or treatment, condoms or abstinence, Africa or Asia, AIDS or poverty reduction. This is not an either/or proposition. We need them all, and more. We need a comprehensive strategy, a truly global response, and an arsenal of tools at our disposal to succeed.

As Peter Piot, Ambassador Tobias, and Hillary Benn of the UK said in a recent op-ed piece:

> "It is high time we leave our flags and affiliations at the door, and find ever new and better ways to get the job done."

I hope you agree.

Thank you. And we ask, Mr. Chairman, that the executive summaries of the reports we have submitted could be included in the record of this meeting.

Thank you.

Mr. LEACH. Without objection.

[The prepared statement of Ms. Cravero follows:]

PREPARED STATEMENT OF KATHLEEN CRAVERO, PH.D., DEPUTY EXECUTIVE DIRECTOR, JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS [UNAIDS]

INTRODUCTION

Mr. Chairman, distinguished members of the Subcommittee, ladies and gentlemen.

I thank you for the opportunity to testify before you this afternoon. I commend you for your longstanding leadership in the global fight against AIDS and for now turning the attention of the Subcommittee and the Congress to the AIDS epidemic in Asia and the Pacific.

This Committee shined a bright light on the burgeoning AIDS epidemic in Africa and drove the enactment of the US Leadership Against AIDS Act of 2003. I am confident that your focus on Asia will ultimately lead to much needed action against AIDS in that region as well. And for that, I thank you.

As you know, the XVth International AIDS Conference took place in Bangkok last week for the first time ever in a developing country in Asia. This conference was intended to be a wake-up call for the region—and by all indications, it may be just that. Much as the AIDS conference in Durban, South Africa was a watershed moment for expanded access to treatment, it is our hope that the Bangkok conference will be remembered as the moment we collectively faced the challenge of AIDS in Asia.

I. THE FACTS

There is little doubt that in the fight against AIDS we once again stand at a crossroads and *Asia is now at the center of the gathering storm.*

Let's recap just a few of the facts that UNAIDS released last week.

- Asia now accounts for nearly 7 and 1/2 million people living with HIV. Last year alone, half a million died from AIDS and more than twice as many—1.1 million—were infected with HIV. In fact, 1 in 4 new infections worldwide occurred in Asia in 2003, compared to 1 in 5 in 2001.
- Asia is now home to some of the fastest-growing AIDS epidemics in the world. This is primarily due to sharp increases in HIV infections in China, Indonesia and Viet Nam.
- In the Pacific, the HIV prevalence rate has reached 1% among women attending antenatal clinics in Port Moresby, Papua New Guinea. High levels of sexually transmitted infections, which indicate increased risk for HIV, have also been documented in Samoa and Vanuatu. As we have seen in the Caribbean, even a small number of infections can have a dramatic impact on small islands populations.
- Although the national HIV prevalence in China and India is low: 0.1% in China and between 0.4% and 1.3% in India—a closer look reveals that both have extremely serious epidemics in a number of provinces, territories and states.
- And let's keep in mind that because the region accounts for 60% of the world's population, even relatively low HIV prevalence translates into millions of lives. While less than 1% of adults in India are HIV infected—this is about 5 million people—more than the entire populations of Botswana, Namibia and Swaziland combined.
- In most places in the region, HIV now remains largely concentrated among marginalized groups such as injecting drug users, men who have sex with men, sex workers, their clients, and their partners. Unfortunately, because prevention programme coverage is still so sparse, infection rates among these groups are skyrocketing—and ultimately will not remain contained.
- Monogamous women, whose only "high-risk" behaviour is being married and faithful to spouses who engage in high-risk behaviour, are being infected and then, sadly, infecting their children. This is how a generalized epidemic begins.
- Timing matters and Asia has a narrow window of opportunity. Because of the dynamics of the epidemic, HIV levels may remain relatively low for many years and then explode quite rapidly. Just look at what happened in South Africa. It took five years for the prevalence rate to rise from .5 to 1% and then it shot to 20% over the next 7 years in the absence of effective care and prevention. While we do not expect something quite this drastic in Asia—it is vital to act decisively before crossing into that epidemiological danger zone.
- Given the size of the population, what happens in Asia will set the tone for the future of the epidemic globally.

An investment opportunity: Act now or pay dearly later

As you know, Asia is a region which has made great economic progress—which is now seriously threatened by AIDS.

A joint study by UNAIDS and the Asian Development Bank (ADB) projects that the human, social and economic losses fuelled by the epidemic will reverse hard-earned development gains if countries in the region fail to promptly establish comprehensive prevention and treatment programmes.

Economic losses due to AIDS were estimated at $7.3 billion in 2001 alone, borne overwhelmingly by AIDS-affected households. This has impoverished millions of men, women, and children.

The region, and all of us in the global community, have clear cut choices to make with very real consequences. If the current trends continue, and we fail to take comprehensive action in Asia and the Pacific:

- a total of 10 million adults and children will likely become infected in the region between now and 2010;
- the annual death toll will increase by 50% to over three quarters of a million people by 2010; and
- economic losses will more than double, amounting to $17 billion annually by 2010.

The good news is we know what works and how to stop the spread of AIDS. "ABC plus" works; harm reduction programmes work; voluntary testing and counselling programs, especially those accompanied by treatment work; interventions to stop mother-to-child transmission work; treating STDs and opportunistic infections work; ensuring a safe blood supply and safe health care settings works; microfinance and

other empowerment programmes for women that reduce their vulnerability work; and fighting stigma, fear, and discrimination, while promoting hope, works.

The problem is—in Asia, as in Africa, only a small fraction of those in need are currently receiving these lifesaving services. For example: less than 1 in 6 of the estimated 2.2 million sex workers in South-East Asia receive basic prevention services. According to recent studies, 6 out of 10 sex workers in East Timor have never heard of a condom, nor have 1 in 3 truck drivers in Pakistan. Only 1 in 50 pregnant women in the Western Pacific have access to efforts to prevent mother-to-child transmission of HIV. In Vietnam, only 1 in 150 of those who need treatment are currently receiving government-provided antiretroviral drugs (ARVs). In China, only 1 in 14 people have had access to HIV counselling and testing—the majority of those infected still do not know their own status.

Increasing access to AIDS prevention and treatment in a meaningful way will require a serious investment. Last year, such a comprehensive effort in the region would have cost at least $1.5 billion—yet only $200 million was spent by all public sources combined.

This resource gap will continue to grow as unmet need grows. And by 2007, the funding needed for AIDS prevention and treatment services in Asia will rise to $5.1 billion annually—approximately $2 per capita. But unlike many countries in Africa, as a region, Asia-Pacific can afford much of this investment. Even when resource needs reach $5.1 billion—this is only 4% of all health expenditures in the region in 2001.

If the necessary leadership and resources are found—from governments in the region and donor support—and comprehensive programs are implemented, we can change the course of this epidemic, and perhaps the course of history. Under this scenario, we can:

- prevent 6 million new infections by 2010;
- reduce the death toll by nearly 100,000 people each year;
- save $2 billion in economic losses each year from 2010; and
- alleviate unquantifiable human suffering in Asia alone.

The experience with the SARS epidemic taught leaders in Asia that public health can have a serious political and socio-economic impact—but with leadership, commitment, and swift action they can make great strides. Several countries, including China and India, have realized that investing in public health is essential to socio-economic development.

Recent statements by Premier Wen Jiabao have signalled China's commitment to implementing strong care and treatment programs and targeting vulnerable groups. Speaking at the closing of the XVth International AIDS Conference, Mrs Sonia Gandhi affirmed the new government's commitment to strengthen its AIDS control effort through increased national funding, greater involvement of civil society, more widespread education and better health facilities. The Prime Minister of Thailand also publicly recommitted to a comprehensive effort including access to antiretrovirals and outreach and treatment programmes for drug users. This type of leadership sets the stage for action and is an essential first step to stopping the march of AIDS in Asia. But more, much more is needed.

II. THE ROLE OF THE UNITED STATES: A GLOBAL LEADER IN THE AIDS FIGHT

US leadership in the global fight against AIDS is highly valued and much appreciated. The US' role has and will continue to be essential to mounting an effective global response, and to action against AIDS in Asia and the Pacific. The US has long been the global leader in providing expertise on AIDS and is now the world's largest provider of global AIDS funding, primarily through the landmark US Leadership Against AIDS Act of 2003.

To date, the US global AIDS initiative's primary focus on 14 African and Caribbean countries has provided much needed assistance to the two regions most heavily impacted by AIDS. We are grateful for this attention. However, as the epidemic expands around the globe, it is increasingly urgent that we undertake concerted action on AIDS in Asia if we are to prevent an unprecedented explosion of HIV infections on the continent.

The recent selection of Vietnam as the 15th US focus country is a very important step in this direction. However, we must view this as the first step of many—initial progress toward a more comprehensive response to AIDS in Asia—and, regrettably, we haven't much time.

Unfortunately, because overall HIV prevalence rates remain low in the Asia-Pacific region, the sense of urgency for action has yet to reach a fever pitch. However, the numbers do not lie, and there is no question that AIDS in Asia is fast approach-

ing a critical tipping point. Given these conditions, it is now more essential than ever that the US and other key donors actively engage the region's political leaders and encourage them to meet the AIDS challenge head-on.

Promoting leadership, investing resources, and sharing experience

The US has had a long and productive presence in the Asia-Pacific region, and is well positioned to provide critical assistance to promote, support, and inform expanded efforts to fight AIDS in the region. The US is already by far the largest donor and provider of expertise on HIV/AIDS in several countries, particularly with regard to strengthening HIV/AIDS surveillance capacity, mobilizing civil society engagement, and implementing and managing prevention, treatment, and care services.

The US has much to offer as a key strategic partner through a three pronged approach to ratcheting up the Asian response to AIDS: (1) by promoting leadership through diplomacy; (2) by providing and leveraging increased resources from both donor and impacted countries; and (3) by offering the training and technical assistance to enhance national capacity.

1) Promoting leadership and sustained political commitment

Although leadership on AIDS in the Asia-Pacific is gaining momentum, the US can help nurture and promote this leadership at all levels through high level diplomacy, encouraging the real and sustained commitments required to implement and manage a comprehensive response to AIDS in the region. There are a number of useful steps that the US can take in this regard.

In the global arena, the US should urge Asian leaders to participate actively in international political fora where AIDS is on the agenda, and help push for discussions around AIDS in Asia where it is not yet being considered. The US should also urge national and international businesses, religious organizations, foundations, academic institutions, and others—in the US and worldwide—with strong ties to Asia to become more engaged in regional AIDS efforts.

At regional and sub-regional levels, the US, through its ongoing participation in key regional diplomatic fora, such as Asia-Pacific Economic Cooperation (APEC), the ASEAN Post Ministerial Conference (PMC), the ASEAN Regional Forum, and the Asia-Pacific Leadership Forum on HIV/AIDS and Development (APLF), should work to ensure that AIDS is and remains high on the political agenda and to build and sustain commitment at the ministerial level.

Specifically, in the case of ASEAN, the US is already exhibiting leadership and supporting implementation of the ASEAN Work Programme on HIV/AIDS. This same level of involvement would be most welcome in the context of APEC, which recently formed a Health Task Force and will be seeking guidance on how best to contribute to the fight against AIDS. With the APLF, the US provides ongoing financial support, and could offer valuable technical assistance as the Forum works to support and strengthen political and civil society leadership on AIDS at the regional and national level.

At the national level, the US should encourage its Ambassadors to Asia to actively engage in the fight, promoting and supporting leadership, leveraging resources, and providing technical expertise and training—responsibilities which US Ambassadors have successfully assumed in Africa and Caribbean as the US global AIDS initiative has rolled out. On the ground, US support should extend beyond national governments, and promote a broad, multisectoral response.

2) Investing and leveraging real resources for what works

To fight AIDS effectively in Asia, the region requires increased financial resources and technical expertise. The US is ideally positioned to provide meaningful assistance in both regards. In terms of resources, the US should invest in what works, leverage other donors and host governments to increase their spending on proven interventions, and promote coordination and cooperation among and between donors and host governments. As we have seen, a firm commitment by the US draws the attention of the international community and promotes healthy competition among donors.

With regard to HIV prevention programs, spending must be dramatically increased to scale up prevention education, through support of an "ABC plus" model, which encourages: abstinence, being faithful, and using condoms—while also promoting female controlled prevention methods, such as females condoms and microbicides, empowering women and effectively engaging men. Given that for many women and girls, negotiating A, B, or C is often not a realistic option, we must provide them with the tools they need to protect themselves. That's what I heard from women leaders in the Mekong region when they launched their coalition on women and AIDS—and that's what I've heard from women all over the world.

It is also essential that funding increase to expand voluntary counselling and testing, harm reduction, and drug treatment programs. Whether the US funds needle exchange programs directly or not, it should recognize the importance of these efforts and promote their implementation in Asia. With regard to AIDS treatment, the US can increase and leverage greater funding to expand access to antiretroviral therapy, as well as medicines to treat opportunistic infections and other sexually transmitted diseases.

(3) Sharing expertise and building indigenous capacity

The US is also well positioned to offer valuable technical guidance, through its enormous reservoir of experience and expertise, both in the US and on the ground. In Asia, as elsewhere, there is a desperate need for capacity building, especially within the health sector; technical assistance on program implementation and management; and training of doctors, nurses, and community workers to provide prevention and treatment services.

There are also dramatic gaps throughout most of the region in terms of monitoring and evaluating, both in measuring the scope and scale of the epidemic and in assessing the value of ongoing interventions. Through its experience with establishing surveillance systems and results-based management, the US could be of real assistance in helping Asian countries strengthen their ability to build and conduct practical and effective systems.

Overall, the US has a central and decisive role to play in the Asia-Pacific. Given the increasing openness, greater political commitment and leadership, and socio-economic development exhibited by many countries in the region, and the grave threat AIDS poses to political, economic, and social growth and stability, this role has never been more important, or more urgently needed. Increased investments in AIDS in Asia by the US and other donors will help to mitigate and avert millions of new HIV infections and AIDS deaths, and help to ensure national and regional security, better governance, and sustained economic growth.

As the US considers increased action in Asia, UNAIDS looks forward to working closely with you in this effort.

III. UNAIDS CAN HELP MAKE A DIFFERENCE

We know that business as usual won't stop AIDS. That's why the Joint United Nations Programme on HIV/AIDS, or UNAIDS, was created. Today, through the leadership of UNAIDS, ten UN agencies and a Secretariat have joined forces in concerted action against AIDS worldwide. In reality, UNAIDS is UN reform in action.

Working globally, regionally, and on-the-ground in more than 65 countries, UNAIDS is helping to develop the leadership, build the capacity, and apply the expertise needed to shape a more effective response to AIDS. UNAIDS is focused not just simply on mobilizing resources—but on maximizing their effectiveness on the ground where the rubber meets the road.

In many ways, UNAIDS is the global knowledge and action fund, capitalizing on the comparative advantage of each of its Cosponsors and partners, and helping to find solutions that bring governments, communities, and donors together to achieve real results.

In Asia and the Pacific, UNAIDS has been key to:

(1) Galvanizing political leadership and commitment:

- In *India*, UNAIDS directly supported the creation of the Indian Parliamentary Forum on HIV/AIDS and nurtured its growth from a gathering of 15 Parliamentarians in 2000 to a convention of 1,500 Parliamentarians with the participation of the Prime Minister and the leader of the opposition in 2003. The commitment of the Parliamentary Forum continues to trickle down and 9 States have now created a State Parliamentary Forum on HIV/AIDS. With support from UNAIDS, similar fora are now being established in Pakistan and Bangladesh.
- In *China*, UNAIDS was key in promoting a high-level awareness of the seriousness and urgency of the growing HIV/AIDS epidemic, and a "Joint Assessment of HIV/AIDS Prevention, Treatment and Care" with China's Ministry of Health. This has lead to leadership at the top and innovative policies adopted by the central Government. UNAIDS is now providing additional support to the government as it seeks to develop an effective multisectoral response and a cohesive and coordinated response at provincial level.
- In March of this year, at a workshop co-organised by UNAIDS, the *President of Fiji and the Chair of the Great Council of Chiefs*, committed themselves to the action against AIDS and called on community, business and religious leaders to similarly commit. UNAIDS is currently assisting other small pacific island coun-

tries with similar political structures in convening traditional leaders to discuss AIDS.

- And at the *Asia regional level*, UNAIDS supported the Association of Southeast Asia Nation's (ASEAN) in convening a special summit on HIV/AIDS and provided resources for country- and regional-level preparations for this summit. Through UNAIDS, civil society, including people living with HIV/AIDS, were engaged in the process of preparing the ASEAN Summit Declaration on HIV/AIDS and the subsequent ASEAN Work Programme on HIV/AIDS.

(2) Enlisting key partners:

- Throughout the region, UNAIDS is considered a neutral broker and facilitator among governments, donors, NGOs, and civil society, including religious leaders and the business community. Recognizing that it will take all sectors of all societies to win this war—UNAIDS has engaged a broad array of partners including:
  - — The Asia Business Coalition on HIV/AIDS, the Federation of Chambers of Commerce and Industry in Nepal, the Confederation of Indian Industry, business coalitions on HIV/AIDS in Indonesia, Thailand, Myanmar, and Singapore and a range of private sector champions in the Philippines;
  - — Mass organizations such as unions, youth and women's organizations in Laos, Vietnam, India, China;
  - — Religious groups such as the Council of the Indonesia Ulama, Lutheran World Federation and Church World Services in Indonesia, Buddhist groups in Laos, Thailand and Myanmar, and various faith-based groups (Muslim, Hindu, Buddhist, and Christian) in Bangladesh;
  - — The national police and military personnel in Laos, Thailand, Indonesia, and Myanmar; and
  - — The International Cricket Council across the region, just to name a few.

(3) Developing and disseminating strategic information:

- Providing user friendly policy guidance and best practice information is critical to ensuring effective evidence-based national responses. To that end, UNAIDS has supported countries throughout the region in the assessment of key programme and policy gaps and priorities and in the development of national HIV/AIDS laws and strategies. UNAIDS has also promoted the sharing of global and regional best practices, including positive experiences from Thailand and Cambodia. In China, 30 UNAIDS publications have been translated into Chinese and widely distributed throughout the country.

(4) And finally, mobilizing and maximizing resources:

- In 2003, UNAIDS provided technical assistance in the development of Global Fund proposals in 13 countries and assisted in other resource mobilization activities in an additional 12 countries. Countries receiving UNAIDS' support were over 4 times more likely to be funded than those who did not. UNAIDS now stands ready in these countries to assist in ensuring that the Global Fund and other money gets out, is effectively utilized, and that program results are tracked and well documented.
- A major achievement in the region took place in Myanmar where, given the very difficult political situation and growing epidemic, UNAIDS helped establish and supports the management of the Fund for HIV/AIDS which channels $24 million from various sources for an integrated and harmonized programme rallying all partners;
- UNAIDS has helped to cost out national strategic plans and assess resources needs and gaps, strengthen the capacities of governments in the region in results based management, and establish monitoring and evaluation systems in 16 countries;
- And most recently, UNAIDS has spearheaded, in cooperation with the US government and others, the adoption of three key principles to drive donor support for concerted action against AIDS on the front lines.

Known as the "three-ones," these principles will help to ensure that our action at country level is in fact country-driven—and that, whatever our respective roles, we all agree to work with:

- one AIDS action framework (strategy, plan) that provides the basis for coordinating the work of all partners;
- one national AIDS coordinating authority with a broad-based multisectoral mandate where all key players are at the table; and

- one monitoring and evaluation system for tracking progress towards achieving real results.

In April 2004, at a meeting held here in Washington, co-chaired by UNAIDS, and the governments of the US and the UK, all major bilateral donors, as well as UN organizations, the World Bank, and the Global Fund agreed to these basic principles.

Too often, efforts to fight AIDS are designed in isolation. And all too often, program managers are forced into being data processors, spending huge amounts of time trying to satisfy dozens of duplicative reporting requirements. This talent and energy—this vital in-country capacity—needs to be freed up to contend with the pandemic, not the paperwork. By being more organized and coordinated in our AIDS action, we can do more and be more effective. This reality was clearly pointed out in the recent GAO report.

We have a long way to go, but the "three ones" gives us a much needed roadmap. The true test will come in the application of these principles, country-by-country, and in our ability to translate this opportunity into prevention, treatment, and support services for the millions in need. UNAIDS has been charged with moving this process forward—and this responsibility is a very high priority for us. We look forward to working closely with the US and are very pleased that the House Foreign Operations Appropriations bill has asked for a quick report on progress in this effort.

CONCLUSION:

In closing, I would like to reiterate that we are at a critical juncture in the global fight against AIDS and the stakes are very high—for Asia and for us all. Success will require more money, more action, but most of all, it will require unprecedented cooperation, coordination, and a framework for moving forward together—particularly at country level. It will take a new way of doing business and a new way of relating to each other.

We have the skill and science needed to stop AIDS. What we need now is the political will, the strategy, *and the unity* to turn the tide.

It is not about PEPFAR or the Global Fund. It is not about prevention or care, condoms or abstinence, Africa or Asia, AIDS or poverty reduction. This is not an either-or proposition. We need them all and more. We need a comprehensive strategy, a truly global response, and an arsenal of tools at our disposal to succeed.

If we take a stand together we can move from the band-aid approaches of the past to providing real and desperately needed HIV prevention and treatment services in communities worldwide.

As Peter Piot, Ambassador Tobias, and Hillary Benn said in a recent op-ed piece—"It is high time we leave our flags and affiliations at the door and find ever new and better ways to get the job done." I agree.

Thank you very much.

Mr. LEACH. Dr. Gill.

STATEMENT OF BATES GILL, PH.D., FREEMAN CHAIR IN CHINA STUDIES, CENTER FOR STRATEGIC AND INTERNATIONAL STUDIES, WASHINGTON, DC

Mr. GILL. Thank you very much, Mr. Chairman, and allow me to begin by thanking you and Members of this distinguished Committee for the opportunity to speak before you today.

I congratulate you, Mr. Chairman, and your colleagues for taking up this issue and examining the looming challenge of HIV/AIDS in Asia more carefully, and gauging its impact on American interests in the region, around the world, and considering appropriate American responses.

I am going to offer a brief summary of my remarks, in three parts. First, an overview. Then I will specifically focus on China, secondly. And third, offer some recommendations for the Committee. I will summarize these points and ask that my formal statement be entered into the record.

Incredible as it seems, Mr. Chairman, each and every day more than 8,000 persons die of HIV/AIDS. Even more astonishingly to me, more than 13,000 persons become infected each and every day. And more people became infected with HIV in 2003—20 years since the outbreak of the epidemic, 5,000,000 new infections last year—than have occurred in any year previously.

With resources for prevention, treatment, and care coming well short of what is needed, the world is falling behind in its effort to reverse this deadly and destabilizing course. Of particular concern to this Committee, the United States and the world now face an even greater challenge, something we term the "Second Wave" of HIV/AIDS in Asia, as it gathers on the very near horizon.

The center of gravity of this epidemic is shifting perceptibly eastward, from Africa, and increasingly affects Eurasia. However, unlike in the past, the devastating consequences of HIV/AIDS will increasingly envelop very large, highly populated, and geostrategically critical countries and regions across Asia, including China, India, Indonesia, and Russia.

Some basic figures tell a troubling tale of the "Second Wave." According to UNAIDS, 8.7 million persons are living with HIV/AIDS today in Eurasia, 1.3 million in Eastern Europe, Russia, and Central Asia, and 7.4 million across Asia. By some estimates, China, India, and Russia alone may account for between 10 and 15 million HIV/AIDS patients in just 6 short years.

More troubling to me is the increasing evidence that the disease is spreading out of so-called source populations, such as injecting drug users and commercial sex workers, and into the general population, driven by pre-marital, extra-marital, and marital heterosexual contact.

Mr. Chairman, our public and private sector here in the United States has not yet fully faced the reality of the "Second Wave," and its implications for the United States, for the important Asian region, and for the world. As you know, China, India, Indonesia, and Russia, and other important Asian countries fall outside of the scope of the President's Emergency Plan for AIDS Relief, or PEPFAR, which is America's welcome and strategic response to the global epidemic.

Given the importance of these countries in Asia to American economic, political, and security interests, however, we need to work on a more coherent and serious strategy to help stem and roll back the gathering threats posed by HIV/AIDS in this critical region.

In the second section, Mr. Chairman, I want to draw largely from a report which we recently issued at CSIS, which focuses on the HIV/AIDS problem in China. Just a couple of findings.

I think we should be heartened that HIV/AIDS has, just in the past 15 to 18 months, been more clearly recognized and acknowledged by the senior political leadership in China. According to official Chinese data, some 840,000 persons are living with HIV as of the end of 2003. But only about 62,000 to 64,000 of those persons have been formally tested and officially confirmed to be HIV-positive.

What that means, Mr. Chairman, is that some 93 to 94 percent of those living in China today who are HIV-positive do not know it, and the government does not know who they are.

If, as I suspect, the actual numbers of HIV-positive persons in China is even higher than the Chinese Government acknowledges, that percentage of HIV-positive persons who do not know their status would be much higher.

The formal remarks that I have submitted into the record go into more detail on these subjects. But I want to make one key point here.

As I have said already, in China, as already in other parts of Asia and the rest of the world, HIV is steadily moving from source populations, such as injecting drug users and commercial sex workers, and into the more general population, where we could expect, as it does, more exponential growth of the epidemic.

Secondly, we should note and welcome that China has made important advances in policy, outlook, and resource commitments at the central government level. New leaders have emerged in China in the past 12 months who are more sensitive and aware of the challenges posed by HIV/AIDS and public health problems more generally.

Very importantly, just last year China instituted, and is now trying to stand up, a comprehensive national treatment plan, known as China CARES. Other targets for China are relatively ambitious, but they hope to have 40,000 persons under treatment by the end of 2005, which will be a difficult target to meet.

Unfortunately, however, owing I think largely to shortages of resources, and especially in terms of training and counselling, the drop-out rate in this treatment program is relatively high, at about 20 percent.

Thirdly with regard to China, formidable challenges lie ahead for them, in spite of these positive changes in terms of outlook and new resource commitments. Key challenges which China will face—and let us face it, in a country with a territory and population as large as China, and also where the problems lie largely in remote and rural areas—lessons learned from other countries that have faced this epidemic may not so readily apply in the Chinese case.

China has an enormous amount of work to do in terms of ramping up its weak and incomplete national testing and surveillance system. China's health care system, formerly so widely recognized as a model for developing world countries, has become dysfunctional, and has unraveled, in fact, over the course of its marketization of its economy.

China seriously lacks qualified personnel to deal with its HIV/AIDS crisis. According to some estimates, China has fewer than 50 doctors—fewer than 50 doctors—who are capable of diagnosing, treating, and monitoring HIV infection. How will it be possible, given the numbers that they face, that they can meet this challenge?

China also lacks a strategic and well-coordinated plan which can invest provinces and localities where HIV/AIDS is at its worst in China to get on board in the same way that central government authorities have done. And also, for both political and normative reasons, China has yet to truly reach out to sensitive and "taboo" populations where HIV prevalence is at its greatest, such as among injecting drug users and commercial sex workers.

In spite of these positive moves, then, in China, Beijing and its international partners can ill afford business as usual or incremental or reactive adjustments to dealing with HIV in China. The United States can seize upon this moment, I think, to build a far more robust partnership around public health, not just in HIV but other issues, with China. These steps are warranted on the basis of U.S. national interests, our increasingly critical relationship with China, and I believe hold the promise of obtaining substantial results.

I have left a number of recommendations here in my formal remarks, but I just want to touch on some very briefly.

I encourage Members of Congress, our Cabinet Secretaries, and other leading policymakers to integrate HIV/AIDS into their dialogue with counterparts in China. I am encouraged in this regard that we are seeing in our Government a reaching out beyond narrowly health care-related discussions with China on HIV/AIDS, and recognizing it as a problem which affects the spectrum of bureaucratic relationships with China, be it labor, education, and others.

Secondly, we need to work more actively with China to see that it expands the space that it offers to corporate and non-governmental actors within its own society. After all, this disease is one that will have to be dealt with at a community- and grassroots-level.

But as you know, civil society is not highly developed in China. It seems to me that this is an opportunity for the United States, through funding and through political encouragement, to help develop civil society in China, community-based organizations and non-governmental organizations which can address such problems as HIV as it affects women and girls, as it affects AIDS orphans, as it affects injecting drug users, and other marginalized parts of Chinese society.

Lastly, I would propose that Congress and the White House give serious consideration to establishing a joint U.S./China Commission on Public Health, which would focus high-level attention on building U.S. partnerships to strengthen public health in China, and mitigate the impact of China's deteriorating public health care system upon U.S. interests. We can deepen our high-level engagement, both public and private, with China on HIV/AIDS, and we should encourage our Global AIDS Coordinator, Ambassador Tobias, to make a visit to Beijing in the near future.

Obviously, bilateral and technical assistance can be further expanded. For example, helping underwrite the placement of external experts at both central and provincial levels to assist China in both the strategic planning and the technical execution of its much-needed HIV/AIDS programs.

Thank you very much, Mr. Chairman.

[The prepared statement of Mr. Gill follows:]

PREPARED STATEMENT OF BATES GILL, PH.D., FREEMAN CHAIR IN CHINA STUDIES, CENTER FOR STRATEGIC AND INTERNATIONAL STUDIES, WASHINGTON, DC

THE COMING "SECOND WAVE": HIV/AIDS IN ASIA

Introduction

Allow me to begin by thanking the Chairman and members of this distinguished Committee for the opportunity to speak before you today. I congratulate you, Mr.

Chairman, and your colleagues, for examining the looming challenge of HIV/AIDS in Asia more carefully, gauging its impact on American interests in the region and around the world, and considering appropriate American responses.

I will offer a brief summary of my remarks in three parts: an overview, a specific focus on China, and recommendations for the Committee. In the interests of time, I will summarize these points, but would ask that my formal statement be entered into the record.

The "Second Wave" of HIV/AIDS

Incredible as it seems, each and every day, more than 8,000 persons die of HIV/AIDS. More astonishingly, every day some 13,000 new infections occur.[1] Nearly half of these infections will be in the world's future—its young people, aged 15 to 24. More people became infected with HIV in 2003—5 million new infections—than in any year since the disease surfaced more than 20 years ago. With resources for prevention, treatment and care coming well short of what is needed globally, the world is falling behind in its effort to reverse the deadly and destabilizing course of the epidemic.

Of particular concern to this Committee, the United States and the world now face an even greater challenge as a looming "second wave" of HIV/AIDS in Asia gathers on the near horizon. The center of gravity of the global epidemic is shifting perceptibly eastward from Africa and increasingly affects Eurasia. Unlike in the past, the devastating consequences of HIV/AIDS will increasingly envelop very large, highly populated, and geostrategically critical countries and regions in Asia, including China, India, Indonesia, and Russia.

Some basic figures tell the troubling tale of the Second Wave. Approximately 8.7 million persons are living with HIV/AIDS in Eurasia today—1.3 million in Eastern Europe, Russia and Central Asia, and 7.4 million in the rest of Asia. Of the 5 million new infections in the world last year, more than 20 percent—about 1.1 million—occurred in Asia. On the Eurasian landmass, India accounts for the largest number of these infections, some 5.1 million, making it the second—and soon to be the first—most afflicted country in the world. China officially counts about 840,000 persons infected with HIV at the end of 2003, but many analysts believe the number is closer to 1 million or more, and that the figure could reach as high as 6 to 10 million by 2010 if current trends continue. Indonesia's epidemic appears largely concentrated in its population of injecting drug users (IDUs) Russia has an estimated 1 million persons living with HIV/AIDS, and could have two or three times as many by 2010. Indeed, Eastern Europe and Central Asia, including Russia, have the fastest growing HIV epidemic in the world today, according to UNAIDS. By some estimates, China, India, and Russia alone may account for between 10 and 15 million HIV/AIDS patients in just six short years.

The epidemics in Asia are centered primarily in two populations: injecting drug users and commercial sex workers and their clients. However, there is increasing evidence that the disease is spreading in the general population, driven by premarital, extramarital, and marital heterosexual contact.

Mr. Chairman, our government and private sector have not yet fully faced the reality of the Second Wave and its implications for the United States, the Asian region, and the world. As you know, China, India, Indonesia, and Russia and other important Asian countries fall outside the scope of the President's Emergency Plan for AIDS Relief, or PEPFAR, America's strategic response to the global epidemic. Given the importance of these countries in Asia to American economic, political, and security interests, we must craft a more coherent strategy to help stem and roll back the gathering threats posed to them by HIV/AIDS.

China's HIV/AIDS Crisis

Mr. Chairman, I will focus the remainder of my remarks on the HIV/AIDS crisis in China. These points are based on more than three years' work examining the HIV/AIDS challenge in China, and more than two decades as a student of China more generally. Our work, generously supported by the Bill and Melinda Gates Foundation and the Henry J. Kaiser Family Foundation, has established regularized and extensive access to Chinese leaders, HIV specialists, health professionals, government and quasi-government organizations, and persons living with HIV, both at national and local levels throughout China. The findings and recommendations pre-

[1] The statistics in this section draw in part from *2004 Report on the global AIDS epidemic* (Geneva: Joint United Nations Programme on HIV/AIDS, June 2004).

sented here are based largely on a recent senior-level delegation visit to China at the invitation of the Chinese Minister of Health.[2]

HIV/AIDS is now recognized clearly as a growing threat to China. According to official Chinese estimates, China now has approximately 840,000 persons living with the HIV virus. As of the end of 2003, only 62,159 persons had been tested and officially confirmed to be HIV-positive. The remaining HIV-positive persons in China—estimated at 780,000 persons or more—are not known to public health authorities, and the individuals themselves probably do not know their status, posing significant risks for the further spread of HIV.

Moreover, outside observers continue to believe that the number of HIV-positive persons in China is higher than China is prepared to acknowledge—perhaps 1 to 1.5 million. Doubt persists, despite improvements in estimating techniques, because China's HIV surveillance system remains inadequate, and indeed is a major obstacle to successfully confronting the spread of HIV in the country. The approximately 62,000 persons officially reported to be HIV-positive represent only 7.4 percent of the total estimated HIV-positive population in China. In some parts of China, the gap between known and estimated cases is even more stark: Hubei provincial health authorities, for example, have confirmed approximately 1,300 HIV-positive persons, but this represents only 3.7 percent of the estimated 35,000 HIV-positive persons in the province.

HIV today is apparently concentrated among injecting drug users (IDUs) and persons infected in the 1990s through blood donations. It is present in all 31 provinces, autonomous regions, and municipalities of China, although the greatest numbers are found in eight hardest-hit provinces and autonomous regions: Yunnan, Xinjiang, Guangxi, Sichuan, Henan, Guangdong, Anhui, and Hubei. However, senior Chinese officials, as well as international experts operational in China, now assert that HIV is steadily moving from source populations such as injecting drug users and commercial sex workers into the general population.

China has made important advances in outlook, policy, and resource commitments at the central government level New leaders have emerged in China with a stronger commitment to improving social welfare and to addressing HIV/AIDS in particular. China has initiated a more proactive response to the HIV/AIDS challenge, including a national treatment and care program known as the China Comprehensive AIDS Response, or China CARES. China CARES aims to provide free antiretroviral (ARV) treatment to 10,000–15,000 persons by 2004 and 40,000 persons by 2005. As of the end of 2003, China CARES had initiated treatment for 7,011 patients, though the dropout rate stands at about 20 percent, largely owing to poor counseling, monitoring and drug side-effects and toxicities.

In addition, new policy guidelines promote "four frees and one care": free antiretroviral drug treatment for poor citizens, free testing and counseling for poor citizens, free treatment to prevent mother-to-child transmission of HIV, free schooling for AIDS orphans, and care for families affected by HIV/AIDS. Senior leaders have committed to steadily ramping up certain sensitive harm reduction strategies, including condom promotion, needle exchange, and methadone substitution therapy for drug addicts.

Also, in February 2004, China established the State Council Working Committee on HIV/AIDS. This move revamped and upgraded the former National Coordinating Committee on HIV/AIDS and Sexually Transmitted Diseases, which had met only four times between 1996 and 2003, and was operated out of a low-level office within the Ministry of Health. The new Working Committee is chaired by Vice Premier Wu Yi, comprises 23 ministries and seven provinces, and meets on an annual basis, with more regular meetings and consultations carried out at the working level. Importantly, the executive office of the new Working Committee is housed in the office of a Vice Minister of Health (currently the office of Vice Minister Wang Longde).

Importantly, in 2003–2004, significant new lines of funding became available to combat HIV/AIDS in China. After being rejected twice, China's application to the Global Fund in 2003 was accepted, promising $32 million during 2004 and 2005. Remaining support of up to $66 million would be made available in years three, four, and five of the grant contingent upon a satisfactory review by the Global Fund of the first two years of implementation. China's application to the fourth round of Global Fund support has also been accepted and will focus additional monies on prevention among certain high-risk groups such as IDUs and commercial sex workers.

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[2] More detailed findings and recommendations in Bates Gill, J. Stephen Morrison, and Drew Thompson, eds., *Defusing China's Time Bomb: Sustaining the Momentum of China's HIV/AIDS Response: A Report of the CSIS HIV/AIDS Task Force Delegation to China*, April 13–18, 2004 (Washington, D.C.: Center for Strategic and International Studies, June 2004), accessible at: *http://csis.org/china/040617—China—AIDS—Timebomb.pdf.*

Chinese central government funding has also substantially increased. For the fiscal year beginning April 1, 2004, the Ministry of Health is expected to receive some 400 million *renminbi* (approximately $50 million at current exchange rates) in funding to combat HIV/AIDS, a quadrupling of funding over 2002–2003 levels.

Formidable challenges lie ahead In spite of these many important changes in tone and policy, daunting challenges—political, technical, and normative—lie ahead for China to successfully meet the goals it has set to combat HIV/AIDS. It is difficult to overstate the scale of the challenge and the impediments confronting the implementation of an effective strategy in terms of planning, costs, logistics, human resources, technical capacity, and tackling the pervasive problems posed by stigma and misunderstanding about the disease.

The scale of the challenge alone—in a country with a territory and population as vast as China, and where the most heavily affected areas lie primarily in remote, rural, and poor parts of the country—is unrivaled in many respects, meaning many "lessons learned" from other countries will not readily apply to the China case. The political will and policy structure has turned in a more positive direction at the central level, but the challenge of combating HIV/AIDS in China must now move into a far more difficult "phase two" of policy and technical implementation at a national, strategic level, and on the ground at the provincial, county, township, and village levels.

Key challenges include:

- Weak and incomplete national HIV testing and surveillance system;
- Debilitated and dysfunctional public health system, particularly in rural areas where HIV is hitting hardest, undermining an effective response to HIV/AIDS;
- Serious lack of qualified personnel and the necessary equipment and technologies to properly diagnose, counsel, treat, monitor, and care for HIV/AIDS patients;
- Major challenges in implementing an effective HIV drug treatment program, with strong risk of emergent drug-resistant HIV becoming more prevalent in China;
- Need for far greater emphasis on HIV education, awareness, and prevention;
- Lack of counseling and confidentiality to accompany expanded testing program;
- Lack of a strategic, well-coordinated plan aimed at winning provincial cooperation and forging effective external partnerships with the private sector and international donors; and
- Need to reform intra-governmental cooperation to stem and prevent the spread of HIV within socially marginalized groups such as drug users, sex workers, and economic migrants.

Conclusions and recommendations

In the past year, China has undergone a dramatic shift of focus, will, and consciousness vis-a-vis HIV/AIDS and public health. These promising changes have driven upward the priority attached to HIV/AIDS, empowered Ministry of Health, energized senior political leaders at many levels, changed the national discourse around HIV/AIDS, and opened the way for the first time in China to address HIV/AIDS and other related infectious diseases seriously on a national scale. However, at this juncture, China and its international partners can ill afford a "business as usual" approach or incremental, reactive adjustments to dealing with HIV in China. The United States should seize upon this moment to build new, far more robust partnerships around public health in China. These steps are warranted on the basis of U.S. national interests, and hold the promise of attaining substantial results.

Sustaining strong leadership Success in addressing HIV/AIDS in China will require continued high-level leadership, both in China and internationally. For engaged U.S. policymakers, members of Congress, and Cabinet secretaries, as well as country leaders and heads of international organizations, priority should lie in near- to medium-term steps which sustain Chinese leadership's focus on HIV/AIDS and public health.

Enhancing strategic planning and prioritization China's formidable structural and organizational weaknesses must be addressed systematically. New national programs potentially pose unfunded financial burdens to provincial and local governments. Failure to implement a more strategically coordinated plan risks the loss of international support over time. Prevention and awareness should receive higher priority in China's strategic national plan to combat HIV/AIDS. High priority should

be given to advancing testing in China. Human resource development, through education and training of medical professionals, is crucial.

Accelerating institutional restructuring and reform High priority should be given to addressing prevention and treatment more strenuously, especially within key at-risk groups. Present organizational structures to combat HIV/AIDS, dominated by the Chinese Center for Disease Control and Prevention, lack the technical expertise and human resources to plan and estimate costs, as well as develop, execute, coordinate, monitor, and evaluate complex national-scale treatment and care programs. China should incentivize health care delivery such that medical personnel become more actively engaged in HIV/AIDS prevention, education, treatment, and care. Particular attention should be given to improving communication and collaboration between central and provincial authorities.

Expanding space for new Chinese and international actors. China's business community and multiplying media outlets have not been meaningfully engaged in support of HIV/AIDS programs. Stronger signals are needed to welcome the special role of both indigenous and international nongovernmental organizations in fighting HIV/AIDS, including the contribution of international businesses in the form of worker education and training and charitable giving. Addressing the acute vulnerability to HIV of women and girls, as well as the growing number of AIDS orphans, increasingly will require enhanced support from communities, educators, and civil society.

Strengthening joint U.S.-China partnership The United States faces an historic opportunity to help shape health-related outcomes in China in ways that are favorable to the interests of China, the United States, the Asia-Pacific region, and the world. Innovative U.S. policies and support to China on HIV/AIDS will contribute significantly to the formulation of a "Second Wave" strategy for such major states as China, India, and Russia which stand at risk of a generalized epidemic but which are presently not a priority focus of U.S. global HIV/AIDS efforts.

Congress and the White House should give serious consideration to establishing a Joint U.S.-China Commission on Public Health to focus high-level attention on building U.S.-Chinese partnerships to strengthen public health in China. It would elevate the priority the two sides explicitly attach to issues of public health and underscore how public health challenges in China increasingly matter to U.S. interests. The Commission might enlist both congressional and administration involvement, and incorporate the widening array of important U.S. educational, religious, business, media, bio-medical/public health, and philanthropic institutions that are becoming significantly invested in health in China.

Deepening high-level engagement by Americans in prominent public and private positions remains essential. The U.S. Global AIDS coordinator, Ambassador Randall Tobias could visit Beijing in 2004. Congressional and cabinet-level delegations to China should include HIV/AIDS issues on their agendas, as could senior corporate and philanthropic leaders in their visits to China.

Bilateral, technical assistance can be further expanded. The United States can underwrite the placement of external experts at central and provincial levels to assist in the planning and execution of HIV/AIDS programs, and increase public and private support for U.S.-China training exchanges, including twinning arrangements between U.S. and Chinese biomedical and public health institutions, including between private hospitals and universities.

Mr. LEACH. Thank you, Dr. Gill.

Dr. Yeldandi. And welcome, from Chicago.

STATEMENT OF DR. VIJAY V. YELDANDI, CHAIRMAN, HIV/AIDS COMMITTEE, AMERICAN ASSOCIATION OF PHYSICIANS OF INDIAN ORIGIN

Dr. YELDANDI. Thank you. Mr. Chairman, Members of the distinguished Committee, I thank you for the opportunity to speak with you this afternoon. And on behalf of U.S./India PAC, the American Association of Physicians of Indian Origin, and the people of the country of India, I thank you for caring.

I would like to put a face on all of the numbers that we have heard this afternoon. There are estimates ranging from 2.5 million to 8.5 million. And these estimates come from a variety of different sources.

They are inherently incomplete, because of the difficulties in working in India. As an Indian, I know how complex this country is, that I have so much difficulty myself understanding. Twenty-eight different states, seven union territories, 602 districts, 16 major languages, 844 dialects. You can move 100 miles from one place to another place, and everything changes: The cuisine, the culture, the clothes. It is a very difficult place to understand.

The other point that is worth understanding is that India lives in the villages. The majority of India's population is rural. The majority of India's gross domestic product—which is important to us to understand how to deal with this epidemic, and to understand the socioeconomic consequences—is created by these people who live in the villages. These are not the people who are taking U.S. jobs by outsourcing or the information industry, or anything like that. They are simply trying to stay alive, just to get enough food to eat, clothes, and shelter. These are the people that we are talking about.

Those of us who have worked in HIV/AIDS and infectious disease in this country, as I have for the last 20 years, have often thought how wonderful it would be if I could go back in time 20 years and try to do something in Africa, knowing what I know today.

Mr. Chairman, we now have this opportunity in India. India is where Africa was. We have a critical time in history to intervene.

The general population is impacted by HIV/AIDS. We now have data from rural parts of India that show that the general population is beginning to get infected with HIV/AIDS. In our own studies, 40 percent of the people who are infected are women. These are monogamous women and their major risk factor for getting HIV was getting married. And the major risk factor for their children getting HIV was they got infected themselves.

So this is the problem that we face. The government of India, under the leadership of the National AIDS Control Organization, the National APEC body for HIV/AIDS, and all of the states' bodies, in concert with the international organizations, have done a wonderful job in trying to address the issues of HIV/AIDS. And God bless them.

The reality is that much of what needs to be done for rural India has not reached there. Ninety percent of the health care that is provided in India is actually in the private sector. This is not cared for by the institutions that are in the government sector. And this is the area that we have the greatest difficulty in reaching. These are the people we need to reach out and support, because they care for all of these poor, rural Indians.

Now, the private sector ranges in sophistication from the best that you can find to completely inadequate facilities. And the latter are what is seen in the rural areas. Many of these rural areas do not have safe drinking water, let alone a competent health care professional who can take care of HIV. So Tuberculosis and Malaria and all of the other infectious diseases that were major public health problems continue to remain major public health problems.

And even though NACO has made substantial progress in improving the safety of blood supply, which is a major accomplishment in India, I can tell you, from my own personal experience,

that for every licensed blood bank there is in certain areas, you can find 10 that are unlicensed, and therefore still supply unsafe blood.

It is extremely important, in order to be successful in averting economic catastrophe, to go in and address all of the public health issues comprehensively. We need to provide safe drinking water; we need to provide access to care for prevention of Tuberculosis, prevention of Leprosy, treatment of everything.

Now, Indians are poor, particularly rural Indians are poor. But they are not stupid. It is impossible to go tell them to use condoms when you cannot provide them clean drinking water. It is impossible to tell them that it is important to avoid getting infected with HIV and avoid high-risk behavior, when we do not have the infrastructure that is needed to provide them a safe blood supply.

The reality is that the government resources, both at the national level, the state level, and the local level, are stretched very thin. Effective monitoring of safety in the health care industry is very poor. And therefore, we need to step in and complement all of the efforts that have gone in at the state level, the national level, and the international level.

What I would urge the United States Congress, the Government, the White House, all to do is to step in and provide the leadership here. You have the ability to avert a major socioeconomic and humanitarian catastrophe in one of the most populous countries, and one of the most beautiful countries, on earth; a country that has supplied 40,000 physicians to this country, an essential part of the health care system of this country.

And I think that if we do a good job in helping India prevent this catastrophe, we will also have the ability to influence India in helping us with our own global agenda in fighting so many other wars in other places.

Thank you, Mr. Chairman.

[The prepared statement of Dr. Yeldandi follows:]

PREPARED STATEMENT OF DR. VIJAY V. YELDANDI, CHAIRMAN, HIV/AIDS COMMITTEE, AMERICAN ASSOCIATION OF PHYSICIANS OF INDIAN ORIGIN

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House Committee on International Relations
Subcommittee on Asia and the Pacific

HIV IN INDIA THE PROBLEM

HIV, the virus responsible for Acquired Immunodeficiency Syndrome (AIDS), was detected in India in1986 in Tamil Nadu. Since the late 1980s India has seen rapid progression of the epidemic with prevalence in all areas of the country. The Government of India estimates over 5 million individuals are infected. The mode of spread is similar to Africa. Initial high risk groups such as intravenous drug users and commercial sex workers in port cities are assumed to be first infected. In India truck drivers are considered a major factor in rapid spread across large geographic areas due to contact with commercial sex workers. Introduction of the epidemic into the general population has occurred with devastating consequences. Monogamous housewives and their children bear the brunt of this modern day plague. Since the HIV epidemic affects primarily the economically most productive segment of the population, the epidemic threatens to become an all consuming conflagration which will negate all of the socio-economic gains of the last fifty years crippling India's economic engine.

The National AIDS Control Organization of India (NACO), charged with developing policy and infrastructure to stem the epidemic, has promoted a national policy statement and a number of guidelines for HIV/AIDS for the Republic of India (www.nacc.nic.in/nacp/curlpol.htm and www.naco.nic.in/nacp/guide.htm) NACO has made remarkable headway in promoting safety of the blood supply, establishing centers for voluntary care and testing (VCT), epidemiological surveillance in sentinel sites and making these reports public. Following on pilot successes Maternal and Child Transmission Treatment Centers (MCTTC), NACO announced in April 2003 that VCT and Antiretroviral treatment (ART) would be made available to pregnant women, in a staged process, emphasizing first the six highest risk states. In December 2003, the Government of India announced a commitment to provide ART to HIV positive individuals, also beginning in a staged process with the highest risk areas.

Even with international and Indian funding, collaboration among NGOs, industry, State AIDS Control Societies and the Indian pharmaceutical industry, the reach and effectiveness of surveillance data gathering, training and treatment services, including VCT and the reach of community based care services, must be dramatically scaled up and brought closer to the people. India's healthcare infrastructure is uneven at best and over 90% of health care delivery is in the private sector. The private health care system ranges from the most modern technologically sophisticated private hospitals which cater to the miniscule segment of the urban elite to ill equipped poorly trained and sometimes unlicensed health care practitioners more prevalent in the rural areas. The public health infrastructure particularly in rural areas leaves much to be desired.

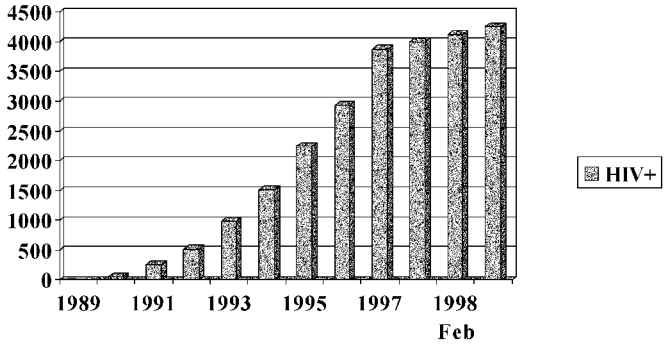
Indian health care regulatory syst :hed to the breaking point and lack of resources make it very difficult to effectively monitor safety of healt ry in the private sector. In the case of blood banks this deficiency continues to constitute a major hazard for transmission of HIV as well as other blood borne pathogens (Hepatitis B and C, malaria etc). Tuberculosis, malaria and in some parts of the country leprosy endemic in large segments of the population continue to strain public health resources.

India with a population of over a billion is a Federal Republic with twenty eight different states and seven union territories. Sixteen major languages each with its own script (Hindi, English, Bengali, Telugu, Marathi, Tamil, Urdu, Gujarati, Malayalam, Kannada, Oriya, Punjabi, Assamese, Kashmiri, Sindhi and Sanskrit) and eight hundred and forty four dialects are spoken in the 602 districts of this vast subcontinent. The enormous diversity of geography is reflected in the culture and socio-economic conditions prevalent in India. Any generalization about conditions in India is difficult. Perhaps the only individual in modern times to really comprehend the kaleidoscope that is India was Mahatma Gandhi, he realized that "India could not attain independence from the British by merely making speeches to the urban elite; an effective campaign required mobilizing the vast masses of Indians who lived in the villages" this is still relevant today in our war against HIV AIDS.

India's population is still predominantly rural and a majority of India's GDP is dependent on this population. Any strategy to combat the HIV epidemic and avert economic disaster cannot focus merely on the urban centers. We must devise an effective approach to address the HIV epidemic in rural India. Rural India with its lack of roads, sanitation, safe drinking water, the enormous poverty and ignorance resembles Africa in many ways and is vulnerable to the kind of HIV induced catastrophe that now afflicts much of sub Saharan Africa.

THE HIV EPIDEMIC IN ANDHRA PRADESH

Andhra Pradesh in south India is one of the high HIV prevalence areas, State Government data demonstrate an exponential increase in the incidence of HIV infection as illustrated by the chart below:



Unfortunately the above data (as most published data from India) is derived exclusively from urban centers. Very little is known about HIV in the rural areas in Andhra Pradesh or any other part of rural India. SHARE "MediCiti" (founded by Americans of Indian Origin) a not for profit health care system comprising of two hospitals a medical school and a school of nursing (www.sharemediciti.org) has initiated a large HIV program based in rural Andhra Pradesh approximately 40 kilometers from Hyderabad the state capital. MediCiti has analyzed its data on HIV over several years from urban volunteer blood donors and found that incidence over several years was relatively stable (data from 1997-2002) 14,185 tested 0.38% are HIV infected, however surprisingly the incidence in rural pregnant women(data from 2001-2002, 1176 tested 1.19% are HIV infected) was three times that of the urban blood donors (OR 3.096: 95% CI 1.717-5.585 p< 0.001). *"HIV Infection in Pregnant Women From Rural South India compared to HIV Infection in Volunteer Blood Donors from Urban South India". Yeldandi V, Yeldandi A, Chundi V, Saluja G S, Oruganti G, Dass S M, Beerum N, Reddy P S. The 41st Annual Meeting of IDSA, October 9-12, 2003, San Diego, CA.*

Alarmed by these findings MediCiti launched an intensive HIV AIDS awareness campaign in the villages surrounding MediCiti. A study of HIV incidence and risk factors was approved by MediCiti's ethics Committee (registered with U.S. Department of health & human services, FWA #00002084) and the IRB at Johns Hopkins University (Baltimore, MD) Preliminary results are available for 5372 participants. Male: 45% ; Female: 55% Age: 18-25: 22%; 26-35:31%; 36-45:22%. 82% married; 10% never married. 5% of all married participants report more than one partner after marriage – Of those reporting so, 88% were men 2% report sexual contact in exchange for money at least once. 1.5% participants report non-spousal partners as most recent sexual partner (sex worker, friend) 98% report never using condoms with most recent partners. Sero-positive Individuals n=69 – HIV prevalence=1.3% (95% CI 1%- 1.6%). 62% Male; 38% Female. 84% 18-45 years of age. 83% were married. 12% reported 2 or more sexual partners pre-marriage and 5% reported multiple partners after marriage. 3% have had more than one partner in the past 6 months. 25% of sero-positives report daily consumption of alcohol.

Many of the participants, particularly women did not perceive themselves to be at any risk. Women confidently proclaimed that they were married and faithful to their husbands and as such they were not concerned about HIV. Most participants were aware that there are testing services available for AIDS. However, the closest center for such testing was the city nearby which was 30 km away from the village site. Condom use was rare. Women associated condom with family planning. Alcohol use was high among men. Women often complained of domestic violence related to alcohol. *"Development of a HIV Voluntary Counseling and Testing Model for a rural population in southern India". Sivaram S, Saluja GS, Manik Das, Reddy PS and Yeldandi V. POSTER at the XV International AIDS Conference, Bangkok Thailand, 11-16 July, 2004.*

Clearly the rural HIV infected individuals particularly the women do not conform to the traditional "High Risk" profile. Therefore an obsessive focus on "High Risk" groups for prevention programs will leave large segments of the population vulnerable to infection with HIV. Also alarming was the total lack of impact of mass media (bill boards, Television, pamphlets, etc) on actual reduction of risk by rural individuals. Interestingly the same experience was noted by the HIV program at Bel-Air Hospital (www.poweroflove.org/program_b_3.shtml) *Personal communication Fr. Tomy.* The role of alcohol as a major risk factor that needs to be addressed is confirmed by the experience of The Freedom Foundation (www.thefreedomfoundation.org) *Personal communication Ashok Rau.* A strong sentiment expressed by many people working in the field is the need to move away from an excessive focus on "High Risk" groups and recognize the vulnerability of all in the risk of acquiring HIV infection. Rural Indians may be poor but not stupid, they see through superficial campaigns which focus on condoms but fail to address the safety of blood supply or safe drinking water. An effective program to combat HIV needs to address basic health needs in a comprehensive manner. Only by addressing all essential health care needs will we have the credibility to address sensitive political, societal/cultural issues which impact on the risk of HIV infection

POSSIBLE SOLUTIONS TO THE HIV PROBLEM IN INDIA

The American Association of Physicians of Indian Origin is advocating additional initiatives to support and complement the programs initiated by the Government of India as well as other entities in India. AAPI is about to launch a major program (CRISP) to address the risk of HIV infection in truck divers in partnership with SHARE MediCiti, The Metro Foundation (www.themetrofoundation.org) and Gati Ltd (www.gati.com). AAPI proposes to partner with Health Care Providers in India to build collaborative programs by establishing five centers of excellence in Northern, Eastern, Western, Central and Southern regions of India. Each center will have a laboratory dedicated to supporting the needs for testing and care of persons with HIV as well as serve as a nucleus for clinical care, education and research. The five centers will be networked by a Web Portal dedicated to supporting health care professionals caring for persons with HIV. The web portal will provide a centralized mechanism for logistics support for arranging confidential testing as well as supply of Anti Retroviral Therapy. This will also assist in tracking the epidemic and its effect in real time thus facilitating resource allocation planning. The basic model has already been validated by MediCiti's REACH program which uses a computerized database to track its rural health care program which has succeeded in achieving better than 95% rates of immunization and antenatal care.

Since over 90% India's existing healthcare services are provided by the private sector, it is essential to reach out to each and every provider and support them by enhancing their skills as well as give them access to supporting infrastructure. The present strategy of relying only on certain designated institutions and "Specialists" is unlikely to be able to meet the demands of the overwhelming numbers of HIV infected persons. AAPI would suggest that each and every provider be assisted in acquiring a minimum core body of knowledge and skills to address (1) HIV and other blood borne pathogens, (2) Tuberculosis, (3) Malaria, (4) Common food borne pathogens, basic hygiene and nutrition, (6) Immunizations. This comprehensive approach is more credible than the present fragmentation of approaches to various infectious diseases which are handled by separate parallel programs. An essential component of a successful strategy is to address health care economics, it is imperative to recognize that health care providers must be able to make a "Living", to insist on altruism alone or charity is unrealistic, we need to assist Indians in creating a viable private health care financing mechanism, once again MediCiti provides a model since a large proportion of operating expenses are generated by patient care revenues which subsidize the rural programs. Philanthropic contributions have gone largely to fund major capital projects.

MediCiti is a project of **"Science Health Allied Research Education"** a not for profit institution founded by Asian Indians in the USA. S.H.A.R.E. has established a healthcare system in Andhra Pradesh (South India) consisting of hospitals, a Medical School, Nursing School, School for Respiratory Therapy, Institute for Craniofacial Surgery (funded in part by Smile Train Inc) and MediCiti Immunology & Infectious Diseases Research Institute

Affordable Comprehensive Health (REACH) serves a rural population of 43,000 in two counties. The villages are economically deprived with a significant population of gypsies who still maintain their traditions. The program encompasses health education, antenatal care, including nutritional supplements, immunization, primary, secondary and tertiary care

clinics staffed by physicians in the villages. Four wheel drive vehicles are needed on rural dirt roads to transport physicians to ambulatory clinics and patients to and from hospital

The Community Health Volunteers (CHV) are responsible for the rural population and ensure that each family is visited at least monthly to update the health status and ensure universal access to care. The program is tracked using a computerized database which updates demographic, socioeconomic and health parameters in near real time.

REACH Blindness eradication program has served over 80% of villagers with cataracts

REACH Staff and CHV go to the doorstep for administering vaccines and micronutrients

The Cancer Prevention clinic staff collaborate with Johns Hopkin s t study the role of HPV in Cervical Cancer

Rotarians visit with HIV patients at MIIDRI

MediCiti Immunology & Infectious Diseases Research Institute

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Jenny Huang, Sarah Kim, and Sheila Am Students from Bayle Austin Texas were p participants of the MediCiti Internation Health and Medical Education Program (IHMEP)

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Mr. LEACH. Thank you. And thank you for that particular expertise on India.

Holly.

STATEMENT OF HOLLY J. BURKHALTER, PHYSICIANS FOR HUMAN RIGHTS

Ms. BURKHALTER. Thank you so much for having me. I am really honored to be here among one of the heroes of the HIV/AIDS activist community, and that would be you.

I remember having heard you speak out on a hot day in front of the Capitol years ago about HIV/AIDS in Africa. And it is very nice to see you chairing a hearing on the topic in the region that your Subcommittee covers. The staff and the board of Physicians for Human Rights are very grateful to you and to your colleagues for your attentiveness constantly throughout the last year, and particularly grateful to this Committee for its leadership in passing the comprehensive HIV/AIDS bill that created the special office in the White House. It has made an inestimable important change and I really can't overstate the significance of it.

Before beginning, I would like to also thank the Physicians for Human Rights researchers who helped me with my testimony: Aaron Fisher, Evelyn Miah, and Eric Friedman.

The doctors for whom I work always talk in terms of best practices, a term that is somewhat overworked. And I was tempted to do that in speaking today because there are some of the best international practices to combat the pandemic and preventive spread may be found in the Asian region.

But then I thought, no, I am a human rights activist; I have got to talk about worst practices. That is what I do for a living.

So I think instead of talking about some of the positive examples from Asia—which you can find on UNAIDS' wonderful Web site, where they have some of the really great examples of community efforts, many of them internationally-funded or U.S.-funded, to deal with HIV/AIDS—I thought instead I would talk about the nexus between human rights violations and the spread of HIV/AIDS, and talk about what a government would do if it actually wanted to spread the pandemic greatly. And I am going to limit my oral remarks to human rights violations. And though you will note in my written testimony, I deal with a lot of other more practically-oriented AIDS transmission means.

If you really wanted to set the stage for the worst HIV/AIDS prevalence in the entire Asian region, you would do just what Burma has done. For example, you would unleash your army into the areas of upheaval in the minority tribal areas, and you would give them carte blanche to destroy and rape and pillage—especially rape—where there has been an absolute epidemic. And it would help drive women and girls and their family members out of the country and into Thailand, and into complete destitution.

You would let your medical infrastructure completely decay. You would destroy civil society. You would jail those who spoke out against these depredations. And then you would, meanwhile, make a killing in profits from the narcotics trade in which you are heavily involved. And then you would end up with a terrifying AIDS

rate, as well as a beautiful country that has been destroyed and has become an international pariah for that activity, as well.

If you wanted to contribute to the spread of HIV/AIDS, you would ignore marginalized groups who are discriminated against within your society. We, at Physicians for Human Rights, just looked at this closely in a report we issued at the Bangkok meeting on Thailand, where a little-noticed aspect of the HIV/AIDS epidemic there are the Thai Hill Tribe women and girls, who are particularly vulnerable to the disease because of their lack of citizenship.

These are people who have lived in Thailand for many generations but are among the 13 Thai minority tribal groups who don't have citizenship, and thus are not able to participate in health care programs. They are those most likely to end up in the sex industry. They are the most likely to have the poorest jobs, the worst jobs in industry. They are the most likely to be raped on the job.

You can double their numbers if you add the Burmese migrants in Thailand who are discriminated against and despised, many of them driven from their own country by the kind of behavior I described.

Those people are at the highest risk of HIV/AIDS exposure. And the much-praised Thailand's prevention program that was particularly strong in the mid-90s, but helped Thailand get a handle on the pandemic and serves as an international model, basically did not reach Burmese and Hill Tribe people, particularly women and girls in the sex industry, from those minority groups.

Third, if you were to actively want to contribute to the spread of the pandemic, you would tolerate trafficking of women and children into the sex industry. Many of the countries of the region have a problem with trafficking. And three of the worst, I think, examples of countries in which child prostitution is tolerated may be found in Asia. India, Cambodia, Vietnam, and Thailand all have a terrible, terrible scourge.

I don't need to develop the concept of why child victims of sexual exploitation are particularly vulnerable. I would simply say that the AIDS pandemic itself drives the trade in ever-younger victims, as men—some of them from the West—purchase children on the notion that they would be safe sexual partners. Now child prostitution and trafficking in adult women, as well, is something that simply does not have to be tolerated and actually can be stamped out, unlike the task of trying to change sexual behavior, the most intimate activities of humanity, which does have to change, indeed.

But really, with regard to trafficking and sexual crimes against children and women, proper policing is an essential health intervention. And it is found almost nowhere in the region.

If an adult, who was set on purchasing a child for sex, can find the child, then the police can find them, too. So this notion that somehow the sex industry is invisible or underground, et cetera, or that if you tried to prosecute it, it would drive it underground, is hogwash. Not every poor country suffers a child prostitution problem. And those countries that would like to end this problem and regain some dignity in the world community will do so with alacrity and without further waste of time. And that goes for the countries that I named.

A further way to contribute to the spread of AIDS is to criminalize and harass and abuse and harm members of populations who are particularly at risk. That would be women in the sex industry, drug users, men who have sex with men.

Lest I appear to be proposing a contradiction about prosecution of trafficking and child prostitution—which I strongly favor—and police harassment and prosecution of non-child, non-trafficked sex workers, I think it is very important to make a distinction. One needs proper policing for what constitutes a violation of the law—child prostitution and trafficking. One does not need police prosecution and abuse and shakedowns and harassment and exploitation of sex workers, which is the kind of thing that keeps them from getting health care. The same goes for IV drug users.

You will find much in the literature from Asia about how few IV drug users, for example, take advantage of health care and prevention services. Or how few male prostitutes, for example, who can go to jail for this activity and die there. You can understand why, then, they would not come in to get tested or receive counselling, much less come in for treatment of sexually transmitted diseases.

You could contribute to the spread of AIDS if you forbade condom sales, or use, or availability, and spread lies about the effectiveness of condoms. And I regret to tell you that one country in the region is doing just that: That would be the Philippines, a Roman Catholic country that has made many forward and positive movements in its human rights picture. But when it goes to education about the way AIDS is transmitted, and the only barrier protection currently available for it, the Philippine authorities and the Church—and I am speaking as a member of St. Peter's Parish—has not done the people of the Philippines a good service. It is contributing to a spread of the disease among those most vulnerable to it.

And finally, I think if you wanted to see the disease spread rapidly in your country, you would arrest the whistleblowers, and you would throw them in jail. And you would stamp out the civil society truth-tellers that are so vital to taking on the HIV/AIDS pandemic, as they were in our own country.

And there, of course, the best examples may be seen in China. In one of the two cases that I am familiar with, Dr. Wan Yanhai, the great AIDS doctor—a very young man—was jailed for 4 weeks after he revealed the blood sale corruption scandal in the poorest provinces of China. Instead of attending to it immediately, the authorities threw him in jail. But he did come out. He is now in the United States.

And we also heard mention from the Chairman about Dr. Jiang, one of China's great heroic doctors, who was briefly jailed for being a truth-teller not only about SARS, but about the 1989 Tienenman Square massacre.

On a much more cheerful note, now that I have given out a somewhat tongue-in-cheek litany of things that governments could do that are wrong and that are harmful, and that are occurring, there are some very positive things about the world today that I think have important bearing on the AIDS pandemic in Asia. And I would like to close by referring to a few of them.

One is that there is a vast HIV/AIDS activist citizens' network. And at the risk of appearing to be kind of a dewy-eyed internation-

alist, I must say that in my 25 years in the human rights field, I have never really seen anything quite like the AIDS activist community that is now linked up by computer so that a leaf doesn't fall in Beijing, or Bangkok, or Seattle, that thousands and thousands of activists who support each other's work everywhere—doctors, nurses, activists, students everywhere—don't know of it.

And let me tell you what that translates into when someone like Dr. Wan is jailed. The United States-based ACT UP, the activists that some of you are probably more familiar with when they hang U.S. policymakers in effigy or shout people down at meetings. I was very touched to see this important group of AIDS activists, these rowdies who are braver than I am in many instances, establish a "Where is Dr. Wan" Web site when their Chinese friend, who they had never met before in their lives, was jailed. And they held demonstrations and were very raucous and very rude outside of Chinese Embassies all over the world. And they kept their petitions and their noise going until, lo and behold, Dr. Wan came out. I thought it was a wonderful sight to behold.

And that goes for an international group of activists who will beat up on the South Africans when they hold back Neviripine for the prevention of mother-to-child transmission of AIDS, and that goes for international joint efforts when the price of drugs gets a bit too high. I could go on.

That linkage between communities and between activists is a resource that is more precious than pearls. And it is there for the countries of Asia, as well, as you can see from the international activists who joined with their colleagues to protest vile depredations against IV drug users in Bangkok this last week.

A second positive note at this 21-year point in the pandemic, or wherever we are, is that the rights, or rather the lack of rights of women and girls, is on the agenda of every nation of this world—most especially the donors—and of the international agencies that work so hard on these issues. Dr. Cravero is a leader of an effort to promote zero tolerance toward violence against women and girls that UNAIDS is spearheading. But you could duplicate that many, many, many places.

I think that it is widely understood that if it were not for the familial and cultural and political and economic subjugation of women and girls, this would be a disease, not a pandemic. And thus, though we don't have all of the answers and we certainly don't have the ways to act on all the answers, we certainly know what the problems are in terms of AIDS transmission and women's lack of ability to control what happens to their bodies in many, many, many situations.

I mean, when we come to the realization that marriage is the highest risk factor for women and girls in Asia, at least we can talk about that. Then we might actually see increasing leadership about the kind of norm change that is desperately needed and that is an integral part of attacking that pandemic norm change with regards to fidelity, and violence, and abuse.

Third, we have another very positive place in history. We have heretofore unimagined sums of money on the table, very much thanks to the Congress and the President of the United States. We can quarrel—and I love to do it—about certain ways the money

could be spent, and must be spent, and should be spent. "I like this, but not that."

But the real point is that there is a huge, new sum of resources that has given hope to everybody, every AIDS activist. And I think that speaks so well for bipartisanship. For this issue, I favor a real big-tent approach on AIDS activism, from the farthest right to the farthest left, both in Congress and amongst the civil society in the United States, that is needed to support the kind of high spending we are going to require forever, as near as I can tell.

The fact is there has been this extraordinary coalition for the first time in my time in Washington, and I think much farther back as well, that has produced vast sums of money and made it available for health in the poorest countries in the world. I, like my colleague, favor integrated AIDS approaches that are built right into primary health care, something that most of these countries don't have at all.

We can start talking about that now. Because we have the Global AIDS Fund, we have UNAIDS, we have the United States PEPFAR, and I hope Asia FAR or something like that. And it means it is a new day in terms of the possibilities of addressing some of the issues my colleagues have talked about.

And then, finally, we have a very good sense of what works and what doesn't work. There are good models to choose from and there are now resources to start practicing them.

We have drugs that are now within the grasp of some of even the poorest countries of the world. And, on a happy note, the major generic producers are all in Asia. Which means that Thai and Indian and Chinese promises to treat everyone who needs it can actually be considered, once the health infrastructure and the other health impediments are addressed.

So without meaning to go on too long, I wanted to give you the bad news first, and follow it with the good news.

Thanks again for having me.

[The prepared statement of Ms. Burkhalter follows:]

PREPARED STATEMENT OF HOLLY J. BURKHALTER, PHYSICIANS FOR HUMAN RIGHTS

Thank you for holding this important hearing, Chairman Leach, and for inviting me to testify. My name is Holly Burkhalter and I am the U.S. Policy Director of Physicians for Human Rights. PHR and its Health Action AIDS Campaign seeks to mobilize the American medical, public health, and nursing professions in support of generous American funding and effective policies to combat the global AIDS pandemic. At today's hearing on HIV/AIDS in Asia, I will reflect on the factors that play a significant role in the transmission and spread of the disease in Asia, and offer some suggestions for U.S. policy.

Before beginning, I would like to thank you, Chairman Leach, on behalf of the staff and board of Physicians for Human Rights, for your long-time commitment and leadership on the international AIDS pandemic. You have been a faithful friend of the poor, the sick, the orphans, and those who care for them since the earliest days of the pandemic at home and in Africa. Your leadership today in calling this hearing on HIV/AIDS in Asia is very much appreciated.

The XV International AIDS Conference in Bangkok earlier this month has brought welcome attention to the so-called "next wave" of the global pandemic. While HIV/AIDS prevalence in even the hardest-hit Asian countries is far lower than in sub-Saharan Africa, even small percentages affected by the virus in the huge populations of India, Indonesia, and China mean tens of millions of new cases in just a few years.

In its newly released report, UNAIDS states that AIDS in Asia is expanding rapidly, with especially sharp increases in China, Indonesia, and Vietnam. The U.N. agency estimates that 7.4 million people are living with HIV in the region and 1.1

million people became newly infected last year. India has the largest number of people living with HIV outside South Africa –5.1 million.[1]

The weak state of most Asian countries' public health systems; the region's endemic poverty; the deeply engrained cultural, economic, and familial subordination of women and girls; the enormous commercial sex industry that includes hundreds of thousands of children and trafficking victims; the growing numbers of intravenous drug users and the stigma and discrimination experienced by people with HIV/AIDS are key factors in the Asian AIDS pandemic. They provide fertile ground for exponential growth in the numbers infected, sick, and dying of HIV/AIDS and a challenge to governments, human rights proponents, and foreign donors to address them forthrightly.

On a more hopeful note, Asia is home to the most important producers of generic antiretroviral drugs. Indian-made products that have been pre-cleared by the WHO are being used by tens if not hundreds of thousands of Africans and are working extremely well. China and Thailand also have ARV production capacity and have committed, as has India, to making them available to all. Another hopeful note is that HIV/AIDS has not broken into the general population in most Asian countries in the way it has in Africa, and there are effective strategies for addressing the locus of HIV/AIDS in many Asian countries—principally commercial sex workers and their clients and intravenous drug users—before it does.

Another vital resource in confronting the AIDS pandemic is vibrant civil society, which many countries in Asia are blessed with. Women's groups are very strong in Asia. And one country in the region, Thailand, is considered by many AIDS experts to be a model of early, coordinated response to HIV/AIDS containment, particularly in the commercial sex industry. Asian governments can learn from the successes and mistakes of the Thai approach, as well as from Latin American, African and Eastern European experiences with the pandemic. It is vital that they do so before the disease reaches the so-called "breakout" point. Experts estimate that once levels reach 5 percent, it often moves extraordinarily quickly throughout the population and becomes very difficult to contain.

In sum, the HIV/AIDS pandemic poses enormous challenges to the people and governments of Southeast and South Asia that will require national leadership and public education about the disease on a much greater scale than has heretofore been seen; a concerted and unstinting effort to eliminate the grossest aspects of discrimination against and exploitation of women, girls, drug users, and people with AIDS; a large infusion of donor financial and technical assistance; immediate attention to dangerous conditions in medical settings that result in disease transmission through tainted blood supply and re-used syringes; and safe public space for civil society. The varied experiences of China, Burma, India, Vietnam, Thailand, Pakistan, the Philippines and other Asian countries provide examples of best and worst practices in these areas that can help inform U.S. policy makers committed to helping Asia address the worst public health crisis in human history.

Details follow:

HIV/AIDS Transmission in the Commercial Sex Industry: Whereas the commercial sex industry is not a principal driver of the pandemic in most African countries, it is considered to be one of the top two factors, along with intravenous drug use, in most of Asia. There are a number of reasons that women, men, and children engaged in commercial sexual activity are at very high risk of HIV exposure. First, they generally have many partners and frequently are forced to engage in unprotected or especially dangerous sexual practices.[2] HIV/AIDS researchers and epidemiologists have found that women and children in the commercial sex industry are the most vulnerable to HIV exposure during their first six months, the time in which the victims have the least ability to protect themselves. They are sought out and purchased for unprotected intercourse because customers consider them safe partners because of their youth and/or inexperience.[3]

Moreover, women and girls in commercial sexual relations have often been subjected to sexual violence before entering into commercial sexual activity. Once they do, they commonly suffer rape and violence at the hands of pimps, predatory police, brothel owners, and customers, particularly when they are trafficked into prostitution against their will. Injuries and abrasions sustained during sexual contact

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[1] UNAIDS. *2004 Report on the Global AIDS Epidemic* (June, 2004).

[2] Anal sex is 30 times more likely to result in HIV transmission; accordingly male sex workers are especially vulnerable.

[3] P.H. Kilmarx et al., "Seroconversion in a prospective study of female sex workers in northern Thailand: continued high incidence among brothel-based women." In: AIDS, 112, 1998, pp. 1889–1898.

heighten physical vulnerability to AIDS transmission.[4] And young girls' physically immature bodies are often injured, significantly heightening their risk of infection. Exposure to other sexually transmitted diseases (STDs), a common problem among those in the sex industry, heightens the risk of contracting HIV by up to a factor of 10.[5]

Accordingly, Asian countries with large commercial sex industries and a significant trafficking problem have very high rates of HIV infection. In India, for example, researchers estimate that 75% of HIV infections have come from heterosexual contact, and commercial sex workers and their clients account for the majority of these cases.[6] Thirty to 60 percent of prostitutes and up to 15 percent of all truck drivers are infected with HIV/AIDS, according to a study by the National Intelligence Council.[7] Research into HIV/AIDS and the sex industry in Mumbai indicated that 70% of the sex workers in Mumbai are HIV-positive.[8] A study in Surat found that HIV prevalence among sex workers had increased from 17% in 1992 to 43% in 2000.[9]

Intravenous drug use (see below) is another high risk factor for women, men, and children in the sex industry. In some countries there is considerable overlap between these two high-risk activities, with stigma attached to both that frequently discourages access to health care or AIDS prevention services.

Thailand is often cited as an example of a successful effort to address HIV transmission in the commercial sex industry. It is worth dwelling on Thailand's experience, and to look more closely at both its successes and failures. On the positive side, the early response to the pandemic by the government of Prime Minister Anand Panyarachun in 1991, who allocated substantial funds to publicize the dangers of HIV and launched a national education, prevention, testing, and care effort is a exemplary model of the impact that government leadership, provision of significant resources, public education and mobilization, and outreach to those most at risk of HIV transmission can have on incidence. The best-known feature of the campaign was its 100% condom program, in which millions of free condoms were distributed to sex workers and their clients. A ubiquitous mass media campaign promoting partner reduction and condom use, and the establishment of a visiting nurse program and local clinic services for sex workers contributed to the campaign's remarkable success, as did the authorities' concerted effort to require brothels to comply with the 100% condom program. From its peak of 143,000 in 1991, the number of new incidents of HIV infection fell to 19,000 in 2003.[10]

Thailand's strategy succeeded in large part because it went beyond simply encouraging sex workers to use condoms, and providing them access to condoms. Studies in Asia have found that along with the problem of condoms simply not being accessible in some cases—something that may be a problem especially for street-based, as opposed to brothel-based sex workers—the other major reason that sex workers do not use condoms is because clients refuse to use them.[11] It is of great significance, therefore, that Thailand involved clients in its interventions, both through its mass media campaign and the breadth of its condom distribution. The authorities, rather than treating sex workers as criminals, supported the 100% condom program. And the campaign went beyond simply encouraging condom use, to also encouraging partner reduction and providing health services for the sex workers. Treatment of sexually transmitted infections is another standard feature of effective prevention programs for sex workers.

The failings of Thailand's AIDS prevention strategies are less well known than its successes, but can help inform efforts in other Asian countries with significant

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[4] *See* UNAIDS, *Women and AIDS, Best Practices Collection* (Oct. 1997), at 3. Available at http://www.unaids.org/publications/documents/human/gender/womenpve.pdf ("Tearing and bleeding during intercourse, whether from 'rough sex,' rape or prior genital mutilation (female "circumcision") multiplies the risk of HIV infection."). *See also* UNAIDS, *HIV/AIDS and Gender-Based Violence fact sheet*, c. 1999. Available at http://www.unaids.org/gender/docs/Gender%20Package/GenderBasedViolence.pdf.

[5] *See* UNAIDS, *Women and AIDS, Best Practices Collection* (Oct. 1997), at 3. Available at http://www.unaids.org/publications/documents/human/gender/womenpve.pdf.

[6] "HIV Prevention with Commercial Sex Workers in Three Communities in India—Project Summary," The Center for HIV Identification, Prevention, and Treatment Services at UCLA (CHIPTS). Available at http://chipts.ucla.edu/projects/chipts/india.html.

[7] National Intelligence Community Assessment. "The Next Wave of HIV/AIDS: Nigeria, Ethiopia, Russia, India, and China" (September 2002).

[8] Shankaran S.S. (2002) "Intervention for women and children in the red light area," Abstract. The XIV International AIDS Conference.

[9] Dutta et al. (2002) "Strategizing peer pressure in enhancing after safer sex practices in brothel setting," Abstract. The XIV International AIDS Conference.

[10] Gorman, Christine. "Back on the AIDS Alert." *Time*, 15 July 2004.

[11] MAP Network, *AIDS in Asia: Face the Facts* (2004), at 35–36.

commercial sexual activity and growing HIV/AIDS incidence. The 100% condom initiative and other prevention activities for those in the commercial sex industry apparently did not reach many of those most vulnerable within it. A report issued last week in Bangkok at the International AIDS Conference by Physicians for Human Rights, called "No Status: Migration, Trafficking & Exploitation of Women in Thailand," notes that HIV rates and risks are higher for Burmese women and girls and for members of Thailand's ethnic tribal groups in the commercial sex industry than for their Thai counterparts.[12] Burmese migrant women and girls, including trafficking victims (see below) and members of Thailand ethnic minority groups suffer discrimination within Thailand and are usually barred from all but the most exploitative and dangerous employment; accordingly they are at risk of being trafficked into prostitution. And to this day, extreme social and legal discrimination against Burmese migrants and ethnic minority women and girls make it extremely difficult for them to access health services, including HIV/AIDS prevention supplies, treatment, and care. Both are prohibited from participating in Thailand's national health plan ("30 baht plan") and women and girls in prostitution are doubly stigmatized. Moreover, government spending on prevention in the sex industry has waned, and HIV rates are again climbing.

Thailand's failure to address HIV/AIDS prevention, health, and human rights among Burmese migrant women and stateless indigenous people has been largely invisible, but it is a problem involving a large number of individuals. There are approximately one million Burmese migrants and a million hill tribe people and they are subjected to an array of abuses that translate into poor health and high risk of AIDS. PHR's team that carried out our investigation into this issue recently visited a clinic serving sex workers in Mae Sot. They found that all were Burmese, and 14% were HIV positive—a dramatically higher rate than among ethnic Thais.

Other lessons for addressing HIV/AIDS transmission in commercial sex venues can be found in India. Peer education, self-organization, STD clinics, and insistence upon condom use by sex workers promoted in the Sonagachi brothel neighborhood of Calcutta since the mid-1990's have been cited by many HIV/AIDS experts as a model of successful outreach to women and girls who are very vulnerable to disease transmission. UNAIDS attributes an increase in condom use in brothels organized by the Durbar Mahila Samanwaya Committee (DMSC) from 10% to 92%, and states that efforts there have held HIV/AIDS prevalence to 10%, as compared to 60% in Mumbai.

DMSC and other sex worker organizations' success in achieving HIV/AIDS prevention victories, as well as helping provide other services for sex workers and their children, are exemplary. The interest of major donors in replicating the model could help provide similar benefits to larger numbers of vulnerable women elsewhere in India's vast commercial sex industry. At the same time, sex worker organizations are not able to end trafficking or child sexual exploitation, which continues to be a serious problem in both organized and unorganized areas.

Whereas Thailand and some states in India have made great strides in promoting condom use by women and men in the sex industry and their customers, the Philippines' government stands out for its explicit decision to deny condoms in public clinics, and spread misinformation about their effectiveness. In a recent report, Human Rights Watch cited Government surveys indicating consistently low and decreasing levels of condom use among sex workers.[13] As of 2002, 83% of reported AIDS cases in the Philippines were attributed to sexual transmission, of which 21% involved male-to-male sex.[14] The Philippine authorities' and Roman Catholic religious leaders' opposition to condom promotion, inaccurate public information about condom efficiency, and dismantling of key prevention initiatives has considerably undermined efforts by the Philippines to confront the pandemic, both within the sex industry and the general population. Similarly, in some Asian countries, including Indonesia and Burma, women are arrested for possessing a condom, which is considered proof of prostitution.[15] Successful prevention campaigns simply cannot be mounted in such an environment.

HIV transmission to and from sex workers is a serious problem in China as well. According to reports, there are some peer educators in China, but there is no free condom distribution program to sex workers and their customers that has been an essential feature of AIDS prevention in the sex industry elsewhere in Asia.

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[12] Physicians for Human Rights. *No Status: Migration, Trafficking & Exploitation of Women in Thailand* July 2004.

[13] Human Rights Watch. "Unprotected: Sex, Condoms, and the Human Right to Health" (May 2004).

[14] Ibid.

[15] MAP Network, *AIDS in Asia: Face the Facts* (2004), at 37.

Trafficking and Child Sexual Exploitation: International health experts have consistently promoted the provision of health care and condoms to those within the commercial sex industry and their clients as an essential element of HIV/AIDS prevention strategy. They should add to their essential interventions strategies to an end the sexual exploitation of children and sex trafficking of women. Victims of these crimes are *not* "sex workers," and providing them with condoms does not assure their rights. Country studies in Asia found that 69% of sexually exploited children in Bangladesh and 70% of those in Vietnam were infected with a sexually transmitted infection, which compounds their risk of becoming infected with HIV/AIDS.[16] Because of their unique vulnerability to HIV/AIDS, injury, and death, their protection and deliverance from the commercial sex industry should be a priority among disease prevention experts, as well as human rights activists. Because child prostitution and sex trafficking are legal nowhere and because the victims of these crimes are offered to the public on a daily basis, it should be possible for the authorities to successfully end such exploitation by providing even minimally competent enforcement of national law. Indeed, there are very few success stories in Asia that could be modeled and replicated.

The PHR report on migration, trafficking and health of Burmese refugees and women and girls from ethnic hill tribes in Thailand found that women and girls trafficked into brothels, bars, factories and domestic service are exposed to HIV because of rape by traffickers, factory bosses, and employers. Trafficking victims in such industries lack language skills, are subjected to abuse and discrimination, and are denied access to health services. As trafficking victims, they are at the mercy of employers and have no access to the protection of local police, who are often complicit in trafficking. Physicians for Human Rights' investigators found that discrimination against both women and girls of Thai minority ethnicity and against Burmese migrants and refugees are a factor in their vulnerability to being trafficked across borders or internally into dangerous, unhealthy, and abusive labor conditions, especially the commercial sex industry.

Several Asian countries have the worst records of child sexual exploitation in the world. Thailand, India, Vietnam and Cambodia have the ugly distinction of being destinations of choice for foreign sex tourists seeking ever-younger partners as protection against HIV/AIDS. Figures on the number of children and adults trafficked into commercial sex are imprecise and vary widely, but there are certainly hundreds of thousands in the countries named. In Thailand alone, some scholars estimate that upwards of 25% of those in the commercial sex industry are minors—some 66,000 of an estimated 250,000 to 300,000 women and girls.[17]

Vietnam, which was recently designated the fifteenth PEPFAR country of focus by President Bush and Ambassador Tobias, is an important choice and provides an excellent opportunity for U.S. policy makers to promote a number of AIDS prevention strategies, including a serious response to trafficking and child prostitution. A survey by the Vietnamese Women Union's Central Committee and the Asia Fund indicated that the smuggling of women and children showed that an estimated 3,511 women and children were sold to Cambodia over the past five years, and that such trafficking is on the rise.[18]

A welcome collaboration to end trafficking in Vietnamese women and children was announced last week by UNICEF, in cooperation with China and Vietnam.[19] According to news reports, Vietnam and China have agreed to jointly strengthen border administration, improve repatriation procedures, establish transition centers, share information to facilitate joint rescue actions, and promote education and awareness of trafficking.[20]

Vietnam is the country of origin for some of the youngest child prostitutes in the world, those found in the notorious brothel neighborhoods of Sway Pak in Phnom Penh, Cambodia. Vietnamese children are sexually exploited after they have been either sold by their parents within Cambodia or trafficked across the border by agents. An unprecedented NGO investigation and a subsequent rescue conducted by the Cambodian police resulted in the seizure of 37 young girls, many of whom were under ten years old, and the youngest of whom was five, from brothels last April. In January of this year, the Cambodian judiciary successfully prosecuted and convicted five perpetrators, who received stiff jail terms. This unprecedented legal action against those who sell tiny children to foreign pedophiles is a rare success story, and Cambodia has been deservedly praised for it. Unfortunately, it is but a

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[16] UNAIDS. *2004 Report on the Global AIDS Epidemic.* (June, 2004).
[17] Ibid.
[18] "Vietnam News Briefs," *Financial Times.* 26 August 2003.
[19] *Asian Political News*, 7 June 2004.
[20] Ibid.

first step. Human rights investigators based in Phnom Penh report that the trade in young children continues and is likely to do so unless the Government of Cambodia commits itself to investigating child prostitution, and prosecuting and convicting those responsible, including Western customers, on a regular and ongoing basis.

Intravenous Drug Users: Injecting drug users constitute another of the groups most vulnerable to HIV transmission, and this constituency is thought to be the locus of infection in many Asian countries. Enormous quantities of opium drugs are produced and transited throughout South and East Asia—particularly in Burma and Afghanistan—and drugs are widely available even to the very poor. A number of Asian countries are now confronting this important source of HIV transmission, but much remains to be done.

With the development of large-scale production of high-grade heroin in the late 1980's, the number of injecting drug users in Asia has grown exponentially. The first, second, and third largest producers of opium are all in the region—Afghanistan, Burma, and Laos. As one researcher put it, the region is experiencing "twin epidemics of injecting drug use and explosive rates of HIV/AIDS."[21] Pakistan, for example, is thought to have 3 million heroin users, and the first outbreak of HIV infection among injecting drug users occurred in 2003. According to UNAIDS, a behavioral survey of injecting drug users in the Pakistani city of Quetta found that a very high proportion used nonsterile injecting equipment and over half said they visited sex workers. Few had heard of AIDS, and even fewer had ever used a condom.[22] Indonesia is home to an estimated two million drug users, half of whom inject.[23]

Intravenous drug users have been the "first wave" of those infected with HIV/AIDS in most Asian countries, including Vietnam, where 65% of all HIV infections are among injecting drug users. This sub-population is at particularly high risk of exposure to HIV/AIDS and other infectious disease. Shared needles, poor health, and unsafe sexual activity contribute, as does stigma, discrimination, and violence, which keep many drug users from accessing prevention and health services.

Levels of HIV prevalence among intravenous drug users are difficult to determine with certainty, but various estimates suggest extremely high rates of HIV among intravenous drug users. Among injecting drug user populations, the prevalence rates of HIV/AIDS indicate the advance stages of a major epidemic. In China, HIV prevalence among drug users in Xinjiang is an estimated 35–80%, in Guangdong 20%, and in countries bordering Burma HIV infection levels of 60–75% have been found among injecting drug users. In Thailand, the prevalence among injecting drug users has remained at approximately 40% for the last fifteen years.

An indication of how swiftly HIV can spread among injecting drug users may be seen in Nepal, where HIV prevalence among injecting drug users rose from about 2% in 1991 and 50% six years later.[24] Likewise, in Manipur, India, a region lacking in any significant intervention program, UNAIDS estimates that HIV rates among intravenous drug users has ballooned to as high as 69%.[25]

Harm reduction services for injecting drug users can play an important role in preventing transmission of HIV. Treatment for drug addiction should be a national priority in most Asian countries—both to secure the rights of injecting drug users and also to address the spread of HIV/AIDS while it is still largely confined to individuals engaged in high-risk activity. Today, it is nowhere adequate to the needs of injecting drug users. Needle exchange, while politically controversial, is considered by most health specialists to be an important weapon in the arsenal of prevention initiatives, and not scientifically controversial at all. A study by the University of California at San Francisco of 81 cities around the world compared HIV infection rates between those cities with needle exchange programs and those without. They found that HIV transmission rates decreased on average by 5.8% in cities with needle exchange programs and increased by 5.9% in those without them.[26]

Needle exchange programs do not encourage drug use. This has been the finding of at least eight federally-funded reports since 1991. An extensive study of a needle

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[21] Reid, Gary. "Intravenous Drug Use Accelerates HIV/AIDS Epidemic in Asia," *Global AIDS Link* (December 2002).

[22] UNAIDS. *2004 Report on the Global AIDS Epidemic*. 4th Global Report. June 2004.

[23] Reid, Gary. "Intravenous Drug Use Accelerates HIV/AIDS Epidemic in Asia," Global AIDS Link (December 2002).

[24] YOUANDAIDS: The HIV/AIDS Portal for Asia Pacific.

[25] "India Facing Serious HIV–AIDS Epidemics, Warns U.N.," *Deutsche Presse-Agentur*, July 3, 2002.

[26] Hurley SF, Jolley DJ, Kaldor JM. Effectiveness of needle-exchange programmes for prevention of HIV infection. Lancet. 1997; 349:604–608, as cited in "Does HIV Needle Exchange Work? By Public Citizen's Health Research Group (December 1998).

exchange program in San Francisco from December 1986 to June 1992 even found that during the course of the study, injection frequency among injecting drug users in the area decreased from 1.9 injections per day to 0.7, and the level of new injecting drug users also fell significantly.[27] The Monitoring the AIDS Pandemic (MAP) Network recently reviewed more than 400 surveillance reports and papers on needle exchange programs, and found no evidence whatsoever that HIV prevention services for injecting drug users, including providing them clean needles, was associated with increased drug use.[28] There is also powerful evidence that needle exchange programs can facilitate access to a range of prevention services, including those that reduce sexual risk of contracting HIV. A survey of injecting drug users in Bangladesh found that injecting drug users who participated in a needle exchange program were about five times less likely to report a symptom of a sexually transmitted infection in the past year than those who did not participate (17% of participants reported an STI, compared to 90% of non-participants). Participants were also significantly more likely to seek medical treatment for sexually transmitted infections.[29] It is clear that providing drug users with drug treatment, health care, prevention education, and harm reduction will not increase drug use, but are key strategies in reversing the spread of AIDS in Asia.

Nepal is cited by prevention experts as a model of harm reduction and AIDS prevention among injecting drug users. A national campaign includes targeted education about the dangers of sharing injecting equipment, outreach workers and peer educators, needle and syringe programs to make available sterile equipment, and some counseling, testing, and therapy.

At the other end of the spectrum is present-day Thailand, where an all-out anti-drug crackdown by the Thaksin government has resulted in thousands of extrajudicial executions of not only drug dealers but drug users. Thousands of arbitrary arrests of drug users, forced confessions, and other abuses have so terrorized injecting drug users that most are in hiding, and few would risk coming forward for health, prevention, or testing services. The number of injecting drug users in Thailand range from 100,000 to 250,000. HIV prevalence among them is estimated at 40% or more.[30] The current approach is radically different from Thailand's comprehensive AIDS prevention program launched in the early 1990's that was a model of harm reduction and humanitarian services for injecting drug users. That approach, in contrast to the one being carried out today, is fairly credited with helping dramatically reduce HIV transmission among injecting drug users.

Through sexual networks and the sex work of some injecting drug users, HIV can spread quickly from injecting drug users to other members of the population. Ensuring effective prevention and treatment programs for injecting drug users is therefore critical both to protect their health and to prevent HIV/AIDS from reaching epidemic levels in countries where drug use is prevalent.

Violence and Discrimination against Women and Girls: Public health experts and human rights advocates have long been aware that women and girls around the world have less control than men over sexual relationships. This reality, and factors such as the desire to have many children, the frequent contact of many men with commercial sex workers, women's economic dependence upon men, girls' lack of education and opportunity and high levels of domestic violence have important bearing on HIV/AIDS in Asia and elsewhere.[31]

Violence against women and girls relates to HIV/AIDS in many ways. The violent transmission of the virus through rape alone is a very important factor, especially in war torn or post-war societies where rape and violence escalate. Partner violence and partner relationships with sex workers, however, is the factor that is most likely to put wives and girlfriends at risk of HIV. In Thailand, for example, one study found that 75% of HIV-infected women were likely infected by their husbands. Nearly half reported heterosexual sex with their husbands as their only HIV-risk factor.[32] Studies in India indicate an even more striking vulnerability among married women: Reportedly 90% of women who test positive at antenatal clinics report monogamous relationships.[33] Inability to negotiate fidelity or condom use has made marriage one of the highest risk factors for women and girls in sub-Saharan Africa in the context of the generalized epidemic; as HIV moves beyond high risk groups

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[27] University of California, San Francisco, AIDS Research Institute, *Does HIV Needle Exchange Work?* (Dec. 1998).

[28] MAP Network, *AIDS in Asia: Face the Facts* (2004), at 50.

[29] Ibid., at 50–51.

[30] "Thailand: Drug War Darkens AIDS Success," Human Rights Watch, July 8, 2004.

[31] "Bridging the Gap: Addressing Gender and Sexuality in HIV Prevention," International Center for Research on, 1998.

[32] UNAIDS. "The Impact of AIDS on Humans and Society" (July 2004).

[33] Cohen, Jon. *Science* Magazine, April 23, 2004.

and into the general population in Asia, these factors will be increasingly relevant there.

Moreover, women's vulnerability to violence at home discourages them from seeking testing, counseling, or even care and treatment for HIV/AIDS. The health and human rights literature includes many references to this phenomenon in Africa.35 It is often the case that women are the first to learn of their sero-status because of testing in the context of prenatal or child birth services. When they do they are at risk of being beaten or shunned within the family and community because the person whose status is first revealed is frequently thought to be the one bringing the disease into the home, although in most cases it is not the woman. HIV/AIDS programs that are sensitive to women's vulnerability to domestic violence related to their HIV status are providing confidential whole-family, simultaneous testing and family counseling.

The United Nations, led by UNIFEM and UNAIDS, is promoting strategies to protect women from exposure to the virus, including community training programs to enhance women's ability to negotiate safe sex, wide distribution of affordable female condoms, and increased funding for the development of microbicides, a barrier method of HIV prevention that is controlled by the woman who uses it. The U.N. is also calling for increased resources for battered women's programs, including shelter and legal assistance, reform of legal impediments to inheritance for widows, and programs to keep girls in school.[34]

Men Who Have Sex with Men: Men who have sex with men[35] are a significant at-risk group in Asia, though numbers can only be estimated, due to the fact that this is a largely hidden population because of extreme social stigma and in some cases, laws, barring homosexual activity and penalizing those who engage in it. The Indian penal code, for example, prohibits "carnal intercourse against the order of nature" and proscribes punishment of up to ten years imprisonment. As a consequence, men who have sex with men generally do not access HIV/AIDS prevention, testing, care, or treatment services.

In some countries, understanding of HIV/AIDS is very low, while high risk behavior among men who have sex with men is common. In China, for example, a 2003 study found that 49% had had unprotected anal intercourse during the previous sex months. This finding, mirrored in studies in Vietnam and Pakistan that show that men who have sex with men are often unaware of the very high risk of contracting HIV through sex between men, likely reflecting the inadequacy of prevention efforts aimed at them. With most prevention efforts targeted to commercial sex between men and women, men are often unaware that male-male sex poses an even greater risk of HIV transmission. This lack of knowledge translates into risky behavior. Studies from across Asia have almost all found that men who have sex with men are less likely to use condoms than men who have sex with female sex workers.[36] Inadequate prevention efforts have also limited knowledge on sexually transmitted infections common in men who have sex with men. The Monitoring the AIDS Pandemic (MAP) Network states that appropriate sexual health services for men who have sex with men, which should be an "important component of HIV prevention services for men in the Asian region," are "currently badly overlooked."[37]

Just as prevention efforts pay inadequate attention to men who have sex with men, male sex workers are often a forgotten population in Asia. Yet surveys indicate that in a number of Asian countries, a significant proportion of men who have sex with men also buy sex from male or transgender sex workers. Surveillance of men who have sex with men at "hot spots" for seeking new sex partners found that more than one-third of men who have sex with men in five cities in India had bought or sold sex in the five months before a surveillance in 2002, and 22% of men who have sex with men in Vietnam had bought sex from a man in the preceding year, while 31% had sold sex.[38] Prevention strategies targeted at sex workers and men who have sex with men must be sure to include interventions for the overlap of these groups.

The fact that many men who have sex with men in Asia also have heterosexual relationships means that there is high potential for the disease to spread to their female partners. In this way, like injecting drug users and clients of sex workers,

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[34] "Empower Women, Halt HIV/AIDS." UNIFEM, United Nations Fund for Women.

[35] The term "Men who have sex with men" is used by health researchers and AIDS activists because many individuals in non-Western countries do not identify themselves either sexually or socially as gay or homosexual, and many are married but have occasional homosexual contacts.

[36] MAP Network, *AIDS in Asia: Face the Facts* (2004), at 57.

[37] Ibid. at 59.

[38] Ibid. at 59–60.

HIV can spread from men who have sex with men into the general population, making prevention efforts that target this group one of the keys to an HIV/AIDS prevention strategy in Asia.

Stigma: The discrimination, abuse, and marginalization suffered by people with HIV/AIDS is not only a violation of their rights, but a significant impediment to addressing the pandemic successfully. Ironically, in some sub-Saharan African countries stigma has been reduced because so many individuals across the social spectrum have been affected by it. But in most Asian countries, where the disease is still overwhelmingly associated with the commercial sex industry, homosexuality, or drug use, people with AIDS are reluctant to reveal their status for fear of being associated with such groups.

There is no substitute for government leadership to reduce stigma and discrimination against both people living with AIDS and those most vulnerable to it. Leaders in several Asian countries have recently taken welcome actions that have been widely publicized. When the Indian Minister of Health, Sushma Swaraj, publicly hugged two AIDS orphans who had been excluded from school, she helped victims of discrimination everywhere. Also striking out against discrimination, China's Premier Wen Jiabao shook hands with three people with AIDS this past World AIDS Day.

Civil Society: A vital component of good governance in the era of HIV/AIDS is tolerance and protection of civil society—especially those groups and individuals who offer desperately needed education on risk reduction and health. Human Rights Watch describes the vulnerability of those who offer such services in India: "The most effective education on HIV transmission is done by those trusted by the community at risk. This means that sex workers have the best chance of helping other sex workers protect themselves from HIV. But peer education is not getting a fair chance in India. The police apparently do not recognize the lifesaving work done by AIDS educators, and these people face consistent abuse." Human Rights Watch's report documents dozens of brutal attacks on AIDS educators over a two-year period between April, 2000 and April, 2002; these attacks have included arbitrary arrest, rape, and even killings.[39]

The most extreme example of government intolerance of civil society in the context of HIV/AIDS can be seen in China, where the authorities are clearly of two minds about the pandemic. Its first response to life-affirming whistle blowers like Dr. Wan Yanhai, a young medical doctor who two years ago revealed publicly the blood sale scandal and official complicity in it, was to jail him without charge for four weeks. Only after a concerted international effort on his behalf by governments and AIDS activists was Dr. Wan released. That same reflexive clamp down on physician who tell the truth—and inestimably aid their countrymen and women by so doing—can be seen in the arrest of 72-year old Dr. Jiang Yanyong, a semi-retired surgeon in the People's Liberation Army who revealed the government's attempt to cover up the SARS outbreak when he recently urged the government to reconsider its depiction of the 1989 Tiananmen Square event.[40] (Dr. Jiang was released from prison two days ago, July 19, through he is expected to remain under surveillance.[41]) And earlier this month, authorities in Henan Province are reported to have closed a school for AIDS orphans and children whose parents were HIV-positive after the school's founder informed them that he was going to join AIDS activities in protests and rallies at the 15th International AIDS Conference. When four HIV-infected farmers tried travel to Beijing to protest the school closing, they were detained.[42]

China has the leadership and outreach to mobilize against infectious disease, as it did during the SARS epidemic. But it will not be able to take on HIV/AIDS if it does not fundamentally alter its approach to civil society. Without courageous whistle blowers like Dr. Wan, the blood sale-generated AIDS epidemic in China's poorest provinces could have remained unnoticed for years.

As in Africa, Asian governments, religious leaders, and civil society must shoulder the burden of massive and ubiquitous public education. The level of knowledge about AIDS in much of India, for example, is staggeringly low. Even those at highest risk—sex workers, truckers, homosexuals—reportedly do not know how AIDS is transmitted, or do not use protection in risky sexual encounters.[43]

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[39] Human Rights Watch. *Epidemic of Abuse: Police Harassment of HIV/AIDS Outreach Workers in India*. July 2002. Available at: http://www.hrw.org/reports/2002/india2.

[40] "Chinese Pressure Dissident Physician; Hero of SARS Crisis Detained Since June 1." *The Washington Post*, 5 July 2004.

[41] Joseph Khan, "China Releases the SARS Whistle-Blower." *New York Times*, July 21, 2004.

[42] Tan Ee Lyn, "Chinese police detain four HIV villagers-activist" Reuters, July 14, 2004.

[43] "AIDS in India," *The Economist*. 17 April 2004.

Medical Transmission: One of the least noticed HIV transmission modes—unsafe medical injections or blood transfusions, accounts for a significant number of infections in Asia.

Injections: According to the World Health Organization (WHO), transmission from reused syringes in health care settings may account for as many as 24.3% of HIV transmissions in a region that includes India, Bangladesh, Bhutan, Korea, Maldives, Burma and Nepal. The same study indicated that 75% of syringes were reused in the absence of sterilization.[44] The fact that people have a great deal more injections than are medically necessary—a study at five health clinics in Indonesia found that 82% of curative injections were unnecessary, for example—and that syringes are used and reused many times translates into hundreds of thousands of wholly preventable HIV/AIDS transmissions every year. While sterile syringes and fully screened blood supply are taken for granted in the West, these standard features of infection control are not the norm in poor countries. Neither governments nor donors have made these important prevention interventions a priority until this year, when the U.S. funded a series of targeted interventions in the context of PEPFAR. Asian countries, like their African counterparts, require technical assistance, supplies, and training to address unsafe health care.

Blood Transfusions: Blood-borne HIV transmission through commercial sale of plasma is thought to be the driver of HIV exposure in China's poor, rural provinces, Anhui, Henan and Shandong. The practice, now discontinued, of poor farmers selling plasma many times, and being re-injected with commingled blood thereafter, caused an extraordinary and concentrated epidemic in communities in these areas. Whole families died, and rates reached as high as 60% in some areas.

Technical experts working with the Chinese government report that the Chinese Ministry of Health estimate that transmission of HIV/AIDS through the transfusion of untested, infected blood accounts for approximately 30% of the spread of AIDS in that country. In India, the experts' sources within the government estimate that approximately 10% of the spread of AIDS in that country is through transfusion of untested/infected blood.[45]

All health facilities must immediately be assured the capacity to test blood for HIV, including the necessary test kits and staff training. Meanwhile, the United States and other donors should provide the technical and financial assistance to enable the countries of Asia to develop comprehensive and effective safe blood distribution networks, that includes recruitment of enough voluntary, unpaid donors to meet national blood transfusion needs; the training and resources to ensure that all blood is screened for HIV and other diseases based on WHO guidelines; a national quality control system, and the appropriate clinical use of blood.

Treatment Preparedness and Infrastructure: The level of treatment in Asia remains low. The World Health Organization estimated that in June 2004, only 55,000 of 1,030,000 people with HIV/AIDS in Asia in immediate need of treatment were receiving it.[46] However, a growing number of countries are pledging to scale-up anti-retroviral treatment and to ensure universal access to AIDS medication, including by providing the drugs for free. As these countries work towards fulfilling their pledges, at least two features will determine the success of AIDS treatment in Asia: the availability of support for treatment, including trained health care workers and community support systems, and the adequacy of rural health infrastructure.

Training: The availability of generic drugs in many Asian countries provides great promise for the rapid roll-out of AIDS medication in Asia. For this roll-out to be successful, however, patients must receive the necessary information and care from trained health professionals. When patients are simply given drugs without the necessary knowledge and support, they are likely to stop taking the medications because of side effects, or because they believe that if they feel better, they no longer need the medicine. Last year, for example, an Indian NGO in Mumbai warned that many HIV-positive people in that city were using anti-retroviral drugs only as their financial circumstances permitted, unaware of the need to continue on the medications once they initiated treatment.[47]

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[44] Hauri, Armstrong, & Hutin, "The global burden of disease attributable to contaminated injections given in health care settings." Journal of STD and AIDS, 2004.

[45] Conversation with Safe Blood International, a U.S. and South Africa-based NGO that is assisting the Government of China.

[46] World Health Organization, *Investing in a Comprehensive Health Sector Response to HIV/AIDS* (2004).

[47] Rupa Chinai, Antiviral misuse in Mumbai, India." *Bulletin of the World Health Organization* (2003) 81(2): 153.

The problem of too few health professionals trained in AIDS treatment is perhaps most severe in China. In a country that officially has 840,000 people with HIV/AIDS,[48] but may in fact have several times that number, fewer than 200 health professionals are trained in comprehensive AIDS care and management, including anti-retroviral therapy.[49] Patients are frequently given AIDS medication without proper consultation. The result has been a very high drop-out rate. Overall drop-out rates are estimated at 20–40%.[50] One investigation in the heavily affected Henan Province found that 40% of people who started on anti-retroviral therapy stopped, often within one month of initiating treatment.[51] The adherence problem in China is compounded by the combination of drugs used in China, which lead to especially strong side effects.[52] China and other Asian countries are therefore in urgent need of training more health professionals in comprehensive HIV/AIDS care. While a multi-pronged approach is likely necessary, one important strategy to consider to quickly reach many health professionals is a "train the trainers" approach, where training is focused on health professionals who will be able to return to their own health facilities and communities and provide training there. A good example is the HIV/AIDS training center that the Academic Alliance for AIDS Care and Prevention in Africa has established in partnership with Makerere University in Uganda.[53]

Trained health personnel are only one component of a successful treatment program. People with HIV/AIDS should have access to community support structures that will both prepare people for treatment through treatment literacy programs, and support those who are on AIDS medication, including by promoting adherence. People need to be educated about the availability and requirements of treatment, so that they will seek treatment and understand how they can make it succeed. As they suffer side effects or other difficulties resulting from treatment, and from HIV/AIDS generally, support from community organizations and other people living with HIV/AIDS is quite important. Through funds and technical assistance, the United States should nurture and encourage these community-based organizations and programs.

Rural Infrastructure: Especially as HIV continues to spread deeper into rural areas in Asian countries, a particular risk because of the enormous numbers of migrant workers in countries such as India and China, the adequacy of rural health infrastructure will be an important factor in how many people can be reached by treatment initiatives in Asia, and how successful treatment will be for those who are reached. AIDS treatment requires chronic care, which entails lifelong contact with the health system, and effective communication between different levels of the health systems. It requires access to trained health personnel who can provide confidential, voluntary counseling and testing. Comprehensive HIV/AIDS care also requires diagnosis and treatment of sexually transmitted infections, treatment of opportunistic infections, education, and condom distribution.

Yet in much of Asia, rural health services are underfinanced and underdeveloped. In 2000, WHO ranked China 188 of 191 nations for fairness of government contributions to health care costs.[54] Government funding covered only about 10.5% of health care expenditures at the township health centers of rural China in 1998, with clinics receiving even less support.[55] What money the Chinese government spends on health mostly goes to urban areas. At least two-thirds of government health spending is directed to cities, even though more than two-thirds of China's population lives in rural areas. Meanwhile, only about 10% of China's rural population has health insurance; the other 90% must pay fast-rising health care costs out-of-pocket.[56]

The Chinese government has recently (October 2002) committed to increasing its spending on the health sector.[57] And in May 2004, the government committed $121

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[48] UNAIDS. *2004 Report on the Global AIDS Epidemic.* 4th Global Report. June, 2004.

[49] Lawrence K. Altman, "Drug Companies in Asia Rushing to Produce Anti-HIV Drugs." *New York Times*, July 7, 2004.

[50] Ibid.

[51] Zhang Feng, "Free AIDS Drugs Trigger Strong Side Effects." *China Daily*, April 22, 2004.

[52] Lawrence K. Altman, "Drug Companies in Asia Rushing to Produce Anti-HIV Drugs." *New York Times*, July 7, 2004.

[53] More information available at http://www.aaacp.org/.

[54] Peter Wonacott, "In Rural China, Health Care Grows Expensive and Elusive." *Wall Street Journal*, May 19, 2003.

[55] Gerald Bloom & Fang Jing (Institute of Development Studies), *China's rural health system in a changing institutional context, IDS Working Paper* 194 (July 2003).

[56] Antoaneta Bezlova, "AIDS doctors dispatched to China's countryside." Asia Times Online. May 8, 2004.

[57] "Injecting More Funds into Rural Health Systems." *China Daily*, April 15, 2003.

million to rural health care as capital for infrastructure projects that would be completed in the next three to five years.[58] While an important start, this amounts to only about an additional 13–15 cents per person in rural China.

India's government also underfunds the health sector. The Indian government spends only 0.9% of GDP on the health sector, less than half the 2.2% average of lower-middle-income countries.[59] Studies have found very high rates of absenteeism in government clinics, and rural clinics frequently lack clean water, electricity, phone service, and an adequate supply of essential medicines. The poor conditions of the public sector health services force many Indians to turn to private doctors.[60]

Building strong rural public health systems in India and China will take time, but are crucial to the long-term success of AIDS treatment, care, and prevention in these countries. The United States should provide financial and technical resources to developing these systems, and encourage leaders in India and China to dramatically increase funding for their government's own health systems, especially in rural areas, and to implement reforms as needed.

Moving Forward: Based on the preceding points, I encourage Congress to take the following steps:

- Encourage the Office of the Global AIDS Coordinator to include in its interventions for regions with a substantial sex industry the best features of Thailand's 100% condom use program and prevention efforts in Calcutta, India. These include: the distribution of free condoms to sex workers; the inclusion of clients in the intervention, including through condom distribution and mass media messages on partner reduction; the support of the police and other authorities to support and encourage the program; peer education and strong involvement of the sex workers themselves in designing the programs; the support of brothel owners, and; the provision of health services for sex workers.
- Encourage and fund a "zero tolerance" campaign towards child sexual exploitation and forced prostitution of adult trafficking victims. Pressure governments to enforce the law against such crimes, assist in the deliverance of child and adult sex trafficking victims from the sex industry, promote the closing of venues where such victims are found and the prosecution, conviction, and punishment of pimps, traffickers, brothel owners, and clients who prey on minors and women held in prostitution against their will.
- Urge that US-funded prevention and treatment programs reach the most vulnerable populations, who are likely to be left out of national programs. Further, Congress should encourage diplomatic interventions to ensure that these most vulnerable populations are fully included in national prevention and treatment programs. Such vulnerable populations include Burmese and ethnic hill tribe women and girls in Thailand.
- Support and fund harm reduction services for injecting drug users. These include needle exchange programs which have been consistently proven to lower HIV transmission rates without encouraging drug use.
- Support HIV services for men who have sex with men, who are often neglected in HIV programs. These programs should also target male commercial sex workers, another often forgotten population.
- In addressing the commercial sex industry and injecting drug use in the context of HIV/AIDS, human rights must be preserved and protected. The terrorizing of injecting drug users and the neglect of Burmese and hill tribe sex workers in Thailand should not be tolerated by the United States. Nor should the United States tolerate harassment and prosecution of men who have sex with men and those who provide HIV prevention, care, and treatment services.
- Support programs that encourage behavior change among men. These are essential to protecting women, many of whom are sexually faithful to husbands who seek contact with commercial sex workers, thereby putting themselves and their families at risk of HIV infection.
- Increase funding and other support for education, including special measures to ensure that girls are able to attend school.

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[58] "China invests 1b yuan in rural health care." Xinhua, May 23, 2004.

[59] Nirupam Bajpai, India's health needs a dose of funds, reforms." *Hindu Business Line*, April 9, 2004.

[60] Celia W. Dugger, "Deserted by Doctors, India's Poor Turn to Quacks." *New York Times*, March 25, 2004, at A1. World Bank researchers found that public sector medical personnel were absent from work 35–40% of the time in India, Indonesia, and Bangladesh. Ibid.

- Request the Office of the Global AIDS Coordinator to report back to Congress on efforts to eliminate legal impediments to inheritance for widows and other codified forms of gender inequality. Encourage the Office to include in country strategies such programs that support battered women, including shelter and legal assistance. Allocate additional funds to a more comprehensive effort to address domestic violence against women.
- Support interventions and resources that will enable women to protect themselves from HIV/AIDS. Wide distribution of affordable female condoms and increased funding for the development of microbicides are essential in this pursuit. The discrimination and abuse suffered by HIV-positive women must be addressed through confidential testing services and public education campaigns.
- Urge that diplomatic pressure be directed at government leaders in Asian countries to reduce stigma and discrimination against both people living with AIDS and those most vulnerable to it. Symbolic action will go a long way in this regard.
- Provide funding for developing rural health infrastructure in Asia, including in India and China. Encourage efforts to India and China to increase their spending on the rural health sector.
- Scale up US support for community-based HIV/AIDS care and support organizations and for training health professionals in India, China, and other Asian countries in comprehensive HIV/AIDS management, including anti-retroviral therapy.
- Support safe health care interventions in Asia.

Conclusion: I have only touched on some aspects of HIV/AIDS in Asia—those that reflect human rights issues that Physicians for Human Rights has focused on in recent years. I believe that Asia possesses resources and leadership that can contain HIV/AIDS before it becomes the kind of generalized pandemic that has destroyed much of sub-Saharan Africa. The United States Government is playing an inestimably important role in addressing the pandemic in Africa. I hope and believe that Asian needs will also become a priority here, and that Congress and the executive branch can work together to support effective prevention, care, and treatment initiatives to address it.

Mr. LEACH. Well, thank you very much, to all of you. And I would like to just comment from a governmental perspective on several things Ms. Burkhalter just mentioned.

And that is that, obviously governments of the world have to lead, both from our perspective and from the perspective of governments in the field.

Just as obviously, in the new world we have there is a huge decentralized private sector thought and capacity that is playing an integral role in all of this. And the note that there is a network of Internet followers of issues is suddenly consequential. And government can't step back because of it, but government has to express its appreciation.

And for those Americans who think that maybe America's smartest entrepreneur is Bill Gates, it is interesting that the Bill & Melinda Gates Foundation has really determined that it is going to sink massive resources into research on cures and viruses and their cures and vaccines. And that says a lot for the private sector, as well.

Let me just begin with a very particular aspect of India. It is my understanding, Dr. Yeldandi, that there is maybe the most interesting research being done in combining antiretroviral drugs in single packages for experimentation in India. Do you know much about this? Has it made an impact? Is it a positive new approach?

Dr. YELDANDI. Mr. Chairman, I do think that it has made a positive impact in the sense that instead of having the ability to only

take care of the super-rich, we now have the ability to at least give treatment to some segments of Indian society that can afford it.

The reality is that, even with the new combinations, the prices you are still talking about are approximately $1,000 to $2,000 a year, which is still out of reach for the majority of the people that are afflicted and are at risk. That is one part of it.

The second part is that those of us that take care of people with HIV disease spend an enormous amount of time and energy and money monitoring them—both for the toxicities of the drugs that they use and also the efficacy.

A particular concern of mine has been that what I have seen in India is that since antimicrobials are available in that country at much lower prices, and a larger segment of society has access to them, there has been an explosive increase in resistance to antimicrobial agents. And I fear that without adequate infrastructure to monitor the use of antiretroviral agents and the training that is required from the health care professionals that manage these things, that the next problem we will see will be antimicrobials not working because of emergence of resistance in HIV.

Also, the currently-available agents are efficacious. They are not necessarily not toxic. The major reason why we use them at levels of toxicity that we will not tolerate in other antimicrobial agents is desperation. These are lifesaving agents. We have nothing else available.

The pharmaceutical industry needs to be prodded into developing the next generation of antiretrovirals, which will be as efficacious at least, but substantially less toxic, easier to use. And we also need to invest a great deal in simply finding and making less expensive the monitoring for all of these treatments that we are proposing.

So I think that the problem is quite complex, particularly when you talk about trying to monitor somebody on therapy in rural areas that don't have roads, don't have safe drinking water, have Tuberculosis. So there are good things and there are not so very good things.

Thanks.

Mr. LEACH. Well, I am told—and let me turn to Dr. Gill—that one of the problems in parts of Asia, there are high instances of TB. And then as you combine AIDS with TB, the likelihood of TB becoming much more virulent is very high. And that TB could become a massive new killer in Asia.

Is that a valid observation, or not? Does anybody on the panel follow this issue? Yes, Doctor?

Ms. CRAVERO. Thank you very much. We actually are seeing, and have seen in Africa, parallel epidemics of TB. And it is the most common opportunistic infection. And very often people finally get tested for HIV because they have TB.

This was given much more attention at this Conference than ever before and will continue to be given priority. In fact, for the Global Fund to fight AIDS, TB, and Malaria, there is a growing emphasis on proposals from countries that propose to look at TB and HIV together. So this is a very serious problem that needs attention.

I was just commenting on what the doctor said earlier on ARVs. UNAIDS agrees that the widespread distribution of ARVs is going to need very careful monitoring and needs the development of health systems. But we can't wait for one in order to do the other.

And I think that the current thinking is that we have to pursue scaled-up treatment programs while we build the health systems, and while we carefully monitor resistance. Because people are dying now. Countries are collapsing. We have to keep people alive long enough to have a critical mass to build the health systems.

So I think everything the doctor said is very true. It is just, given the situation right now, we have to move on several fronts at once.

Mr. LEACH. Fair enough. Let me just make one final question to Dr. Gill.

You commented on the infrastructure in China, and the problem with the lack of doctors, as well as the numbers issue. And you also suggested that we ought to be sending Ambassador Tobias to Beijing.

And I am just trying to think in terms of perspective. We have a number of issues that we may have confrontation with China, from economics to politics. It strikes me that we ought to be stressing cooperation in this area as maybe the number one American agenda, vis-a-vis China. Does that seem to be a credible perspective, or not?

Mr. GILL. Two points in response, Mr. Chairman. As the doctor has already noted about the emergence of resistance and the problems of monitoring and treatment in India, so too, this is going to be a major concern in China as well, as most of the disease at the moment is afflicting rural and remote and resource-poor parts of the country.

And already, in fact, we have learned of black markets in drug treatment in China with substandard quality, which is already driving a sort of new resistant epidemic within China, which will not be treatable by any currently-known drug.

So this is a problem which I presume affects a lot of resource-poor places around the world. But when you are looking at the numbers which we are about to face in countries like India or China, the problem becomes all the more difficult.

I quite agree with you, Mr. Chairman, that, given the many, let us call them great power difficulties we might face with China going forward, whether it be in security areas, obviously perhaps in the form of trade competition, we could do a lot more, I would think—and I think the Chinese would welcome, in fact—greater cooperation in, let us call them non-traditional areas of great power cooperation and security. Like on drug trafficking, counter-terrorism, HIV/AIDS, and other public health challenges.

And I am encouraged, actually. I do believe that this is something that can receive bipartisan support. It is just that so far, because of the nature and the enormous challenges we already know about in Africa, that thus far, the question of whether or not this should be a central aspect of our relationship with major countries in Asia has not really risen up to the top of, or near the top of, the agendas where it needs to be.

So I would strongly encourage this Committee and others across our Government to see this as an opportunity for building a more

constructive relationship with this important country, China, and others, given some of the other difficulties we do have with them.

Mr. LEACH. Thank you, Doctor. Eni.

Mr. FALEOMAVAEGA. Thank you, Mr. Chairman. I just wanted to ask Dr. Cravero a couple of questions about the operation of her agency, the UNAIDS.

I am pleading ignorance here, so you will have to help me in terms of how does your organization relate to the operations of UNESCO and the World Health Organization? And I believe there is also within there the Planned Parenthood problems of population, and realizing also that two-thirds of the world's population resides in the Asia-Pacific region.

But I am curious. Does your organization have a very visible appearance in the United Nations in terms of your operations and the kind of priorities? You are saying that we have to make this a real high, high priority. And I want to ask, is this a real high, high priority with the United Nations in terms of allocations of the resources that are given to operate?

Ms. CRAVERO. Thank you very much. The UNAIDS is a very different organization. It is unique in the U.N. system. It is actually a partnership of 10 organizations, with a Secretariat that exists to facilitate their efforts.

So UNDP, UNICEF, UNFPA, and the World Food Program, as well as UNESCO, WHO, ILO, the World Bank, and the U.N. Office for Drugs and Crime, and the U.N. High Commissioner for Refugees are all co-sponsoring organizations of UNAIDS.

It is the only area of work of the U.N. where there is that kind of partnership. And we actually have a joint or unified budget and work plan that we put together every 2 years, which again is the only area within the U.N. where such a collective work plan is put together. And that actually does reflect the U.N.'s conviction that we have to approach this epidemic differently; that all the agencies doing their own thing and getting together once a year is not going to work.

We actually are in constant touch. There are peer reviews of programs making sure that we don't have gaps, that we are not duplicating each other's work and that we are making the most of the resources that are available to us.

And as I indicated in my testimony, one of the key areas of work for the U.N. is coordination, because the U.N. has a certain amount of funding. But our funding is very, very little compared to the Global Fund to Fight AIDS, TB, and Malaria, or big bilateral programs like the President's new initiative.

One of our key roles is to make those other investments work better. Which, as I said, we have been on the ground in over 30 countries, working with governments and national partners to develop their proposals to the Global Fund, or to develop their proposals that the U.S. Ambassador will then put forward for PEPFAR.

So it is really a leveraging function that we play, and bringing everyone to the table. Making sure that when governments are putting their Global Fund or PEPFAR proposals together, they have civil society represented there working with people living with HIV, et cetera.

So it is a very different kind of organization and operation. And we think has a clear value added in an increasingly crowded field with more money. In fact, as the money gets bigger, the role gets more important.

On Asia, we have offices in almost all Asian countries. And we work very closely with the representatives of the other U.N. agencies. So we have something on the ground called AIDS Action Groups, or theme groups, where the U.N. representatives of all the agencies work together in supporting national partners.

Mr. FALEOMAVAEGA. So with all these regional U.N. organizations that are coordinating with your operations, so the staffing of UNAIDS alone is, what, you are talking about, what, 1,000 people working?

Ms. CRAVERO. Well, it depends on how you look at UNAIDS. The Secretariat—that is, for instance, in any given country—would have a small staff of maybe one or two people. But the role of the Secretariat of UNAIDS is to work with the staffs of our co-sponsoring agencies.

So if you take a country like India, the UNAIDS Secretariat perhaps has five people in India, but we are coordinating and facilitating the work of all the U.N. agencies on AIDS in India.

Now, if you put all those staff together, you are talking about at least 100 in India. So it is elsewhere——

Mr. FALEOMAVAEGA. Okay. I am sorry, I have listed a couple of things. I am just impressed with the way the whole thing was being organized. I thought the United Nations was bureaucratically over everything. I mean, it needed to cut down on so much of the bureaucracy that goes on there. But the way it sounds, you seem to be operating very effectively among all those regional organizations.

I have got a couple of listings here, competing interests, competing priorities, limited resources, and the complexity of the issue itself.

In terms of the priorities of how the United Nations is addressing this very issue, how does AIDS come into the listing of maybe the five highest priorities that the United Nations is currently addressing? Where would you put AIDS in the list of the five highest priorities that the U.N. is now addressing?

Ms. CRAVERO. I think the Secretary General has made it clear that in terms of development priorities, HIV/AIDS is his number-one priority globally. Because it is his belief, he has made it very clear and I think has driven that home with the Executive Directors of U.N. organizations, that——

Mr. FALEOMAVAEGA. Well, not just from the Secretary General. I just want to get a sense from the United Nations as a whole.

Ms. CRAVERO. As a development issue, it is the top priority right now.

Mr. FALEOMAVAEGA. Okay, good. And I was going to ask Dr. Yeldandi if he was any relation to Vijay Singh. Are you related to Vijay Singh?

Dr. YELDANDI. No, sir, I am not.

Mr. FALEOMAVAEGA. Unfortunately. You are not my friend, then.

You have made some very eloquent statements about the crisis that we face in India. Obviously because of limited resources, what

can we do? Even by the commitments of our own Government, while we have made a lot of commitments, but when it comes to substance, very little. But I can say, at least, for our own country, we are making a bigger commitment than most other countries.

What would be your recommendation on how we could look at the picture of the Asia-Pacific region, how we can best address it? As we have done in Sub-Sahara Africa and other regions.

Dr. YELDANDI. Thank you, sir. I think the key issue is how we get to strengthening the entire public health infrastructure. Therefore, what we need to insure is that each and everybody gets the basic needs addressed: Clean water, access to immunizations, access to antenatal care, basic nutrition. And that HIV, Tuberculosis, Malaria, everything needs to be included in this comprehensive approach.

The major reason why our own organization has been able to go into rural areas in a very conservative society and talk openly about sexuality, HIV and AIDS, is because of our track record with public health over there. We have been working with immunizations and micro-nutrients for pregnant women, so——

Mr. FALEOMAVAEGA. I know my time is up, Dr. Yeldandi. But let me tell you, it isn't just your country that has these cultural problems with sexuality. I can tell you a whole story about that, but I am going to wait for another round.

I am sorry, my time is up. But I will follow up on that.

Mr. LEACH. Thank you. Jerry.

Mr. WELLER. Thank you, Mr. Chairman. And I want to thank your panel for what is a very enlightening and informative discussion this afternoon.

Recognizing my time is limited, I will get right to my questions. And I would like to direct this question to Dr. Cravero. And if others on the panel would like to respond, I would like to hear from you.

But we focused quite a bit on India in this discussion today. A very large country with a large population, but it is projected by many experts that India is going to have the largest HIV/AIDS population by 2005 in the world. I think today is it number two. We expect it to be number one within a year.

And many experts and observers have also stated that the government of India's commitment to this crisis has not been very high. In fact, some of them say it is questionable, considering the amount of resources that the government of India has devoted to this challenge in comparison to what the international community is doing.

And Dr. Cravero, would you say this is a fair assessment? And from your perspective, what concrete steps have you seen the Indian Government take to address this crisis?

Ms. CRAVERO. I think it is a fair assessment to say that the government of India has been slower than we would have liked to see to really take this problem in hand.

I think we have seen a great improvement in the last 2 to 3 years, not only at the national level, but more importantly for India, at the provincial level. Because as you know, there are states in India that are as populous as the United States. So to say whatever the national government does in India is one thing, but it is

the provincial governments you have to reach, also, as I think the doctor has pointed out.

So we think there has been an improvement. In India it is very uneven. There are some states with very big problems. You know, overall it is between 0.4 and 1.3 percent. But in some states in India it is a huge problem; in other states it is much less. So we can't just take a national approach, and that has been an issue.

It is probably worth stating that Sonia Ghandi came to the closing session of Bangkok, and that was seen as very significant. Because it was the first time an Indian leader had addressed an international Conference, and had talked about the problem in her own country and what the government intended to do about it. So that was a very positive sign.

Mr. WELLER. Thank you. Dr. Gill, others on the panel, want to respond to my question?

Dr. YELDANDI. I think that they should be commended for doing all that they could do and can do in the short time.

The government of India and all of the state governments have very limited resources. They don't have much money. That is the reality. And whatever little money they have they have been trying to use.

This is the reason why it is so important for the United States and other international agencies to come in and augment what they are doing, and complement the deficiencies. We need to step in there.

No matter how hard you try, when you are working as a government agency, like NACO or the States AIDS Control Society, they have inherent limitations in what they can do. And we need to step in and complement them by strengthening the other private sector, and the non-governmental organizations that are out in the field, in the trenches, so to speak.

Thank you.

Mr. WELLER. Dr. Yeldandi, as a follow-up to that, obviously you are an observer and directly involved in trying to address this challenge in India. You have stated that you feel that they have done quite a bit. What more can they do? Are there specific initiatives from your experience that you would recommend that they adopt, recognizing the resources that they have available?

Dr. YELDANDI. From the perspective of the American Association of Physicians from India, what we would like to see is that India, both at the national level and at the state level, really beef up their infrastructure support. Laboratories for testing, training for health care professionals, and also increasing access of antiretroviral agents.

These have to be done in parallel, like Dr. Cravero said. We have a lot of people who are going to die today or tomorrow, so we cannot wait for better agents to come along. We have to use the agents that we have. But we need to use them wisely. And therefore, an enormous investment needs to be made in building the infrastructure that is required to monitor them.

This is where the United States can come in. This country has the technology. This country has the management expertise. And most importantly, we are a generous people and we care for people who are less privileged than we are. We have demonstrated that

for many years. And we need to come in. And I think that we will make a difference if we come in.

Mr. WELLER. Well, Dr. Yeldandi, I certainly want to thank you for participating. Since I represent the Chicago area, it is good to have someone from the neighborhood.

Dr. Gill or Ms. Burkhalter, do either of you have some comments, particularly on India and how they are devoting their resources and efforts?

Ms. BURKHALTER. If you will permit an Iowan to speak for just a moment on that point.

I wanted to talk about a technical issue, largely technical issue, that I didn't raise up in my oral remarks, but you will find it in my written statement. It is less of a conventional human rights issue, like those I was talking about, and more of a classical disease prevention method. And that is AIDS transmissions through tainted blood, unscreened blood in blood transfusions or in reused needles.

I worked on this a lot last year with regard to Africa, where it is less of a problem than it is in Asia. But it has been somewhat minimized by international health people. The disease is customarily referred to as a sexually-transmitted disease.

Really, not to be pedantic about it, but HIV/AIDS is a bloodborne disease. And you cannot neglect classical infection control.

If you have a blood transfusion from a person who has AIDS to a person who doesn't have AIDS, there is a 100-percent chance that the person to whom the transfusion has been given will get the disease.

And it is worth saying that in Africa and in Asia, there are not blood banks like we have here, where blood is tested, and you have donors who are not paid for blood and the rest of it.

If you need a transfusion, you bring in your transfusion with you. It is a family member, most often. And for people with Malaria, who have to have a transfusion right away, there is no way to test these people. There is no testing availability, quick test for HIV/AIDS in the blood.

And even if there was, there isn't another place to go to get a blood transfusion. So you either get this transfusion or you are going to die.

And in the Asian region, according to WHO, something on the order of 25 percent of HIV/AIDS transmission is from these unsafe health care contacts. I am not talking about street use of IV drug use; I am talking about dirty needles, reused needles, or blood supply.

The Chinese, for example, some have estimated that 30 percent of their AIDS transmission comes from blood transfusions.

Now, it is not a minor matter to clean up a blood supply or to substitute non-reusable or self-destruct syringes for the reusable type. It is not minor. But nor is it impossible. It is not rocket science. I mean, these are relatively cost-effective interventions that are technical and practical in a nature that can solve the problem.

If you think about a third of the infections that could be prevented, and if you compare that to trying to change sexual norms and promote condom use in every single household in some of these

high-prevalence countries—I absolutely agree with Dr. Cravero. You don't pit one prevention initiative against another. And that is the last thing I would want to do.

But I think that this has been a bit of a neglected kind of stepchild, because it is not sexually transmitted. And because of the international community's eagerness to address what has been neglected in the past, which is sexual transmission, and speak frankly about it, this issue has been somewhat left behind.

I mean, India has a huge problem with this. Both reused needles, as well as infected blood supply. And—and this will be my last statement about this—the amount of medical injections that poor people in poor countries receive is vastly higher than here.

I had one injection last year; it was a flu shot. But a poor Indian woman might have 10 or 12. And there is a very good chance that it will be with a reused needle.

You know, if you will permit me a personal observation, 9 years ago when my husband and I went to China and adopted our daughter, Gracie, the adoption agency told us to be sure and take safe, clean syringes. And we said, "Why? What for?" I never worked on AIDS before, what did I know about this? Well, if you get sick, you certainly don't want to get an injection from a Chinese hospital. And I think any United Nations employee and anybody who works in our Embassies in Asia and Africa would say the same.

When we got to China, our daughter was very sick, as were many of the other kids. They are all fine now, by the way; they just flourish there. A wonderful, wonderful Chinese gift to the United States.

But some of our kids were sick and we took them to a clinic. And the first thing these wonderful providers wanted to do for these foreign-adopted kids, who they wanted to offer the best thing they had in their generosity and kindness, was to give them a shot.

They were just sick; they had diarrhea, they were sick from poor orphanage conditions. We didn't let them give the kids a shot.

But I think that little personal story suggests to you what we actually know about one form of disease transmission. And if you think AIDS is transmitted in large numbers, you wouldn't believe the Hepatitis numbers, which are in the tens of millions.

And this is just plain fixable. And this is a kind of technical fix and help that, the blood supply is a bit complicated, but can be done. It takes some money, it takes some help.

Now, China, I am informed, is working with the, I should say the Clinton Foundation is assisting the Chinese Health Ministry with their blood supply and other technical issues. It is going very well.

So I would really like to second Chairman Leach's suggestion and Professor Gill's suggestion about a different kind of a relationship around this issue, where two great nations of the world can exchange experiences on public health. It would make me very, very happy, as the mother of a Chinese-American child.

Mr. WELLER. Thank you, Mr. Chairman. I realize I have gone well beyond my allotted slot of time, but thank you. It was a very worthwhile discussion.

Mr. LEACH. Your contributions are always outstanding.

Mrs. Lee, a leader in Congress on so many AIDS issues.

Ms. LEE. Thank you, Mr. Chairman. And let me first thank you for allowing me to participate in the Subcommittee hearing, and also commend you for your leadership at this very important time, this very critical time.

And I always remind people when I talk to individuals, those involved in this whole pandemic, that really the precursor and the framework for the Global Fund was through the legislation which we co-authored together, that created the World Bank AIDS Trust Fund. And I think we have seen at least a glimmer of hope and some progress. And it is very important that we continue to move forward and try to get to the $1 billion, $2 billion which the fund so desperately needs.

Let me just say also, I think the Subcommittee hearing is coming at a very important time, especially since the International AIDS Conference in Bangkok just ended its proceedings. And I had the privilege, actually, to participate in that Conference. It was only maybe 3 days, but I think it was a worthwhile 3 days.

And I must say to you that I talked to many, many people at the Conference. And the issue as it relates to the vulnerability of women and girls in the new face of HIV and AIDS was on everyone's mind.

I would like to, Mr. Chairman, insert for the record Secretary General Kofi Annan's statement at the Conference in Bangkok. I would like to ask for unanimous consent for that.

Mr. LEACH. Without objection, so ordered. And the Secretary General has played a really extraordinary role on the AIDS issue. And given all of the controversy that surrounds the United Nations, I think that we ought to be very firm in expressing our appreciation when it is doing well. And both UNAIDS, as well as the Secretary General, have shown extraordinary leadership.

Ms. LEE. Thank you, Mr. Chairman. So I will insert his statement into the record.

Let me just read a quote from the opening ceremonies in Bangkok. He said:

> "Over the past few years, we have seen a terrifying pattern emerge: all over the world, women are increasingly bearing the brunt of the epidemic. . . . And yet, one third of all countries still have no policies to ensure that women have access to prevention and care."

In many cases, and I mentioned this when I was in Bangkok, and I would like to ask any of the panelists to respond to this point. The point I made that I have heard over and over, and that I know, is that oftentimes women and girls don't really have the option to abstain, because of everything that we have heard today.

And while many people—it is very interesting—in our own country understand this and commented on my comments, I was amazed at some of the most vicious communications that I received within the last week with regard to my statement.

It was very interesting because some of those vicious, very ridiculous comments said that—and let me just read a couple of them. One said that women can always say no, so why are you saying this? Another comment which frequently came up was that Congresswoman Lee, you are a wacko. It is only through rape that

women have no choice, and you can't force a rapist to use condoms. I mean, the type of bizarre type of response that I received from many people concerned me quite a bit, in terms of just the thinking and the mentality of those who really don't seem to get it.

So we have introduced—and Ms. Burkhalter, I think you mentioned in the Philippines—this whole issue around condoms, the misinformation and not allowing the sale of condoms certainly contributes to the spread of AIDS. Well, that is just the point.

And so we are trying to figure out a way to develop legislation that would put together a focus with regard to access to female condoms, reducing the child/marriage issue, reduction of violence, helping to increase micro-enterprises for women, generating income generation initiatives, increasing access to health care services, and to promote overall gender equality.

I am proud to say we have a bill that is pending, H.R. 4792, with about, I guess, 54–55 co-sponsors. And I would just like to ask, well, starting with Dr. Cravero, your comments on what you think a focus strategy on behalf of our Government should look like as it relates to women and girls, so that we can begin, one, to address the pandemic in a very real way for these millions of women and children.

But secondly, to educate the American public as to why this not allowing the distribution of condoms, not allowing for a comprehensive strategy that involves education, prevention, abstinence, be faithful, and condom use—how do we convince the American people that this is the only way we can address this pandemic?

Ms. CRAVERO. Thank you very much. And I would like to thank, on behalf of UNAIDS, Congresswoman Lee for what she has done in this new bill we plan to use as a model—model legislation to share with other countries about the kind of legislation that is required to address the realities of women and girls' lives.

As I said in my testimony, we believe that for women and girls, truly there needs to be a comprehensive prevention approach.

It is clear, if you look at how women and girls live in developing countries and what their situation is—not only in developing countries, and not just young women in particular, but women of all ages—they simply don't have the ability to abstain. They are not in a position to demand faithfulness, and they are not in a position to negotiate condoms.

And as part of the Global Coalition on Women and AIDS, which UNAIDS has spearheaded, we are trying to build the evidence base for some of this. And we do have evidence for it.

In South Africa there was a recent study published which showed that women who lived with partners who were violent or controlling—and it was a proper operational research study, so they defined violence and controlling. But women who lived with partners that were violent or controlling were five times more vulnerable to HIV than those who were not.

We know that in Thailand, 40 percent of new infections are spouse-to-spouse or partner-to-partner infections, male to female. I mean, the evidence is growing, if people needed to be convinced by such evidence.

And what we are saying very clearly is that abstinence, fidelity, and condoms are a good start, but we need to go further. If you

don't reduce violence against women, they are never going to be in a position to negotiate anything. If you don't protect women's property rights after their partners die, they will inevitably engage in high-risk sexual behaviors in order to survive. If you don't guarantee girls access to education, they will have to sleep with older men to pay their school fees.

Again, as was said earlier on, this is not rocket science. Now, we are trying to build the evidence base. Some people are never going to be convinced of this because they don't want to be convinced.

But I think if you look both at how transmissions are occurring and anything about the way girls and women live, you can see how an "ABC plus"—emphasis on the "plus"—strategy is absolutely necessary.

Dr. YELDANDI. If I may make a comment on that. I think that what you have brought up is vital to understand. And 40 percent of the women that we are seeing, 40 percent of the people that we are seeing infected with HIV are women.

And one of the major issues that we face is that there is a lot of alcoholism involved. And alcohol and violence in the domestic setting is a major contributor to all of the HIV spreading.

You know, it is very interesting that Mr. Chopra, who is one of the founders of the Freedom Foundation, once told me about alcohol and sex. And he said you know, these commercial sex workers, you think that these people really enjoy what they are doing? They have professional gratification? No. They have to do it 10, 12 times a day to make a living. And they dull the pain by using a lot of alcohol. And their clients do the same. And it contributes to the spread.

So in addition to the legislative activity that is absolutely imperative to empower women, what we also need to do is, on the ground, we need to empower women. Now, we have done that by making sure that all of our community health volunteers are women. These are women with 6th-grade educations. They are leaders in their own community because they are our liaison with the entire community as health care workers. This has raised their profile in the community. They are respected. And that enables them and empowers them to take more control over their own lives.

Ms. LEE. Mr. Chairman, may I have an additional couple seconds?

Mr. LEACH. Absolutely.

Ms. LEE. Thank you, Mr. Chairman. I had the privilege of being able to visit India in January. Actually I went to Mumbai and visited a brothel and was very startled at what I saw.

But in visiting the brothel, as in visiting commercial sex workers in Zambia last year, 99.9 percent of the women said to me that they would not be doing this type of work if they had an alternative, one. And secondly, they wanted to know more about how to protect themselves, two. And thirdly, really asked for a lot of assistance, just in terms of basic kind of assistance, in terms of living arrangements, in terms of health care, in terms of day care and what-have-you.

So it is common worldwide. And I believe, just as it relates to India, Mr. Chairman, the bill, and I think you are a co-sponsor of H.R. 4449, we are trying to ensure that India becomes a country

of focus by the President in terms of his initiative. I believe Vietnam was the 15th country, but that doesn't mean that we can't add additional countries in terms of the focus of our strategy in this country.

And I would just like to get your take on, well, I don't know if you have read this legislation or not. But basically it would just require our own efforts to add India as a focused effort. Do you think that would help us move forward in terms of addressing this pandemic before it grows to over 1 percent? Because now, with 4.5 million people, we are right on the cusp of a very, I think, serious situation.

Dr. YELDANDI. You are exactly right. We are where Africa was 10, 15 years ago. And this is the time that we need to move forward with all deliberate speed and seize this opportunity.

India has done some work. And we may quibble with whether their efforts are adequate or inadequate. But clearly, so much more needs to be done that it is beyond the resources of that society to do it all alone. We need to step in. And the United States of America needs to take a leadership position on this.

Thank you.

Ms. LEE. Thank you, Mr. Chairman, very much. And thank you again for your leadership.

Mr. LEACH. Well, it is your leadership I want to thank. And I want to tell you, you certainly have my mandate to do the Committee's investigation on brothels. I am not sure that my constituents want me to explain my investigations in such circumstances. But I appreciate very much your insights.

If you have any callers that suggest you are wacko, tell them to talk to me, and I will whack them.

Ms. LEE. I will do that. Thank you very much, Mr. Chairman.

Mr. LEACH. At least verbally. And as everybody knows, Barbara is really the leader of Congress on some very profound issues.

Eni, do you have any further questions?

Mr. FALEOMAVAEGA. I just want to add, Mr. Chairman, to the gentlelady's comment about her being described as a wacko. I just want to say for the record that Ms. Lee has been the wacko, and also has been the leading advocate and the stalwart in this Committee. In fact, one of the most powerful voices in advocacy about the AIDS/HIV crisis and the development of the legislation that came off from the Committee. And I want to compliment the gentlelady for her leadership and her efforts in fighting this dreaded disease.

So I don't know whether to say that being described as a wacko is a compliment or a criticism. But I want to say that I associate myself with Ms. Lee as a wacko, if that is how they think of her, as a wacko. But as far as I am concerned, they don't know the extent of how the gentlelady has been one of our best advocates. Not only has it given national attention, but international attention about the HIV/AIDS. And I just want to say that for the record.

And to say also, Mr. Chairman, that, as Ms. Burkhalter has said, there are so many issues interconnected, it isn't just with HIV/AIDS. You are talking about Hepatitis, you are talking about Malaria, you are talking about TB. And every country, especially developing countries, have these basic fundamental needs.

So it is such a—I say it is a contradiction. We claim to be a sophisticated country; I don't know about that. When we talk about sex issues, and how Viagra and Levitra comes out in the middle of a football game. And children ask their parents what is erectile dysfunction, whatever that means. It causes me to wonder if we know ourselves about sexuality. And how do you describe a condom?

In cultures, in my own culture, you talk about sex, it is almost the forbidden story. Or to the extent that you don't talk about it as freely as you would maybe in our society. And do we say that would be hypocritical? I don't know. But there definitely is a strong cultural problem to overcome.

To say that we are more educated in that process, I doubt it. I think we are just as ignorant ourselves in trying to figure that one out. The constitutional proposal about prevention of gay marriages and all this is health-related, as well.

I think I come away more—not frustrated—but I come away more concerned that the issues are so tremendous. And I sincerely hope that maybe what we can do is start off with India. Let us start with India. If we can address that issue, maybe we will move on to the next area in addressing this very serious issue.

And again, Mr. Chairman, I thank you for calling the hearing. And I want to commend our panelists for the tremendous contributions that they have given. And hopefully, as a result of this hearing, we will come out with some good policy decisions by way of legislation to help the President, and help our country, as well.

Thank you, Mr. Chairman.

Mr. LEACH. Thank you, Eni. And I want to thank our panelists. Your testimony was excellent.

By the way, at hearings you have three, four, five Members of Congress sitting through. But we are going to put your testimony up on various Web sites, one of which is the U.S./China Commission, but others, as well. So with your permission, we will do that.

Personally, I am very impressed with the emphasis on the word "plus" today. And it has taken on dimensions that I think we all have to think more about. One, Ms. Burkhalter's emphasis on needles and blood supply. A second, which I have given almost no thought to, is Dr. Yeldandi's emphasis on alcohol.

And so, with the leadership of Barbara Lee and one of her predecessors in spirit, Cary Nation, we can move on.

But these are very extraordinary circumstances.

I also, which is a new concept to me, am impressed with the thought that if you address a health care problem of one kind, that you can use that to develop other positive circumstances. So that a clinic on AIDS can be a clinic for more general health care needs, and vice-versa.

And that notion that AIDS can be the cutting-edge issue to deliver greater health care of a broad assortment to less-sophisticated health care delivery societies, which to some degree includes the United States—that is, we are at the forefront of virtually everything in health care, except our delivery mechanisms are not as perfect as they might be.

And AIDS as a technique of addressing, or an emphasis on AIDS is a technique of addressing other health care issues is, I think,

something that deserves a lot more attention. And I am glad that as a set of panelists you have raised that to our attention.

In any regard, I thank you all for sterling testimony. And hopefully we can get your perspective out to larger numbers of people. Thank you all very much.

[Whereupon, at 3:29 p.m., the Subcommittee was adjourned.]

APPENDIX

MATERIAL SUBMITTED FOR THE HEARING RECORD

PREPARED STATEMENT OF THE HONORABLE DAN BURTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF INDIANA

Mr. Chairman, I commend you for convening this hearing today to examine the prevalence of HIV/AIDS, and strategies to combat the spread of the disease in the Asia-Pacific region. The Asia-Pacific region is home to 60% of the world's population and to 19% of the men, women, and children living with HIV according to the latest statistics. Infection rates in Asia are low compared to some continents, particularly Africa, but because the populations of many Asian nations are so great, even low HIV prevalence translates into large numbers of people living with HIV/AIDS—some 5.1 million men, 2 million women and 158,000 children according to the most up-to-date estimates from UNAIDS/WHO.

There are alarming rates of transmission in Cambodia, Thailand, Myanmar, parts of Southern China and India where efforts to limit exposure and reduce infection levels have not been succeeding.

In 2003, close to half of the intravenous drug users (IDUs) receiving treatment in the Indonesian capital, Jakarta, were living with HIV. While in 2002 in Nepal, HIV prevalence among male intravenous drug users ranged from 22% to 68% across the country. Parts of China, India, Myanmar, Thailand and Vietnam have all recorded very high levels of HIV infection among IDUs.

In some places (including Myanmar, Thailand and the Indian state of Manipur), HIV infection rates have "stabilized" among IDUs, but they have stayed at levels of between 40% and 60% for nearly a decade. Unfortunately, even stable prevalence means that one person becomes infected for every HIV-infected person who dies or drops out of the population because they stop injecting drugs.

Clearly, the problem is severe and immediate. A few of the countries in the region have recorded significant successes in their campaigns to prevent HIV/AIDS infection, but there are obviously a number of other countries in the region that need to substantially strengthen their policies in order to combat their growing HIV epidemics.

From the outset let me say that I support the Bush administration's $15 Billion U.S. AIDS relief plan. The President's Emergency Plan for AIDS Relief (PEPFAR) grants funds to health care groups in individual countries that emphasize a focused "A–B–C" approach to HIV/AIDS prevention: "Abstinence," "Be Faithful" and "Condom Use." Some may argue that this is too simplistic an approach but the fact of the matter is that not having sex is a sure way to avoid contracting a sexually transmitted disease.

Let me also point out to those critics who say that the United States isn't paying its fair share for the global fights against HIV/AIDS, that the U.S. contribution to the global HIV/AIDS fund continues to be greater than those of all other donor governments combined. In 2004 alone, our contribution will be approximately twice that of all other donor governments combined.

I believe this Administration is firmly committed to the battle against HIV/AIDS and I know that in Asia, our government working through USAID will continue to step up efforts to assist governments and non-governmental organization in their prevention and treatment efforts.

Based upon my own travels throughout the region and from the hearings this Subcommittee has convened in recent months, I have gained an acute appreciation for the wonderful diversity of the peoples and cultures of the Asia-Pacific region. Likewise, the HIV/AIDS epidemics in the region share a similar diversity. Prevention efforts that ignore the social, political and cultural contexts that push people into engaging in risky behavior will simply not encourage people to adopt safer be-

haviors. Efforts that ignore or minimize the risks of this devastating disease or are conducted piece meal to narrowly targeted groups are also likely doomed to failure. I think we've seen the evidence of this in our own country as we struggled to deal with the HIV/AIDS crisis during the 1980s.

Public health practitioners seem to have a natural tendency to target interventions towards people who engage in certain risk behaviors, and to classify them as special "risk groups," somehow separated from the "general population." As a Nation, we have learned through years of combating this debilitating disease that we are all part of the "general population," and it is in our collective best interest to provide prevention services and care for all those among us who may be at risk of contracting and passing on HIV/AIDS. We have also seen around the World that countries and regions that have chosen to provide prevention services on a large scale to those who are most in need of them, have turned their HIV/AIDS epidemics around or at least significantly delayed the onset of looming epidemics.

Attitudes towards drug abuse, commercial sex, and sex trafficking are all factors contributing to the complexity of designing public health interventions to combat the spread of HIV/AIDS. For example, when we look at behavioral patterns in Asia, I find it alarming that a seemly high percentage of HIV/AIDS prevention programs have focused strongly on reducing unprotected commercial sex between men and women, and very little on tackling risky sex between men or between men and transgender individuals. Similarly, in most Asian countries, a majority of both female sex workers and intravenous drug users are younger than 25; and a significant proportion of men who buy sex and who have multiple male sex partners are also adolescents or young adults. Yet, intervention and prevention programs aren't appropriately reaching out to this generation.

There is obviously a great need for technical assistance—particularly in the area of education—to appropriately design programs to modify behavior patterns in these countries. For our own sakes, we must do more to help the Asia-Pacific region deal with this epidemic. The solution isn't necessarily throwing more money at the problem, rather it is throwing new ideas at local policymakers and helping them work through the challenges and stereotypes they face when trying to put prevention and intervention programs in place. I look forward to hearing the thoughts and suggestions of our witnesses in just how to go about doing this.

In closing, I would like to submit for the record today a study by the Monitoring the AIDS Pandemic Network—an international network of epidemiologists and public health professionals who contribute data and analysis in their individual capacities. I have found this study to be extremely helpful in my own understanding of the subject of HIV/AIDS, and I commend it to all colleagues. Thank you.

PREPARED STATEMENT OF THE HONORABLE BARBARA LEE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Thank you Mr. Chairman for allowing me the opportunity to participate in today's very important hearing.

Let me also just say that your leadership on this critically important issue has been extraordinary over the last few years. It's truly been a privilege to work with you so closely in drafting and passing legislation that truly makes a difference in the lives of people throughout Africa, Asia and the developing world. And I look forward to our continued collaboration.

Mr. Chairman, I'm pleased that the Subcommittee is holding this very timely hearing today, especially coming as it does on the heels of the XV international AIDS Conference in Bangkok, Thailand.

As the only Member of Congress to attend this incredibly important event, I want to take a few minutes to give this committee and the panelists my impressions of the conference.

Each time I've returned from one of these conferences, I'm filled with great hope, but also a very profound realization of just how much it is that we have left to do.

Having spent this last week among the international leaders on the global pandemic, I can tell you that the international community is very disappointed by the rate of progress, particularly in meeting the goal of the conference "Access for All".

There was also great concern about the US position on a number of issues including funding, HIV prevention, drugs, support for the Global Fund, and even just the number of US government attendees at the conference.

In fact, that point was reinforced by Secretary Tommy Thompson's decision to allow a delegation of only 50 people from HHS to attend the World AIDS conference this year, down from 236 the year before in Barcelona.

It is shameful that they have prevented many of our very best and brightest scientists at the Center's for Disease Control, and the National Institutes of Health from gaining new insights from their colleagues in the international community.

It is tragic that this Administration's unilateralist and ideological tendencies have now spread to the fight against HIV/AIDS.

It is morally wrong to allow right-wing ideology to trump science when it comes to the Administration's HIV/AIDS prevention policies. Their policies set aside 33% of all funding for abstinence only programs which deny access to life saving education and technology, including condoms.

Simply put: this is irresponsible, unethical, and inhumane.

I believe it is unethical that their AIDS treatment policies are focused more on protecting patents and big pharmaceutical companies than on the urgent need to get fixed dose combinations into the hands of those who need them, 98% of whom lack access to treatment. The emphasis should be on saving lives.

It is disingenuous that they have proposed cutting our support for the Global Fund by over 60% this coming fiscal year, proposing a measly contribution of $200 million rather than the $1.2 billion that is needed.

We need to encourage the sharing of information by our scientists and researchers.

We need to do a lot better in coordinating our bilateral programs with national governments, the NGO community, and our field missions.

We need to simplify our anti-retroviral treatment programs by purchasing fixed dose combinations, drugs that are already available, and we must standardize our treatment programs according to the wishes of each individual country.

We have to Fund the Fund!

Last week I offered an amendment to the Foreign Operations Appropriations bill to bring our total level of funding up to $1.2 billion this year. And I was very disappointed that a point of order was raised to kill the amendment, because I believe the fund is the best way to get the money out into the hands of the NGO's immediately.

The Fund takes a multilateral approach, and it has the potential to leverage vast new resources. We are the wealthiest country in the world. And we should be leading the charge.

Perhaps most importantly, we must stress and implement a balanced, comprehensive, HIV prevention policy that includes Abstinence, Being faithful *and* Condoms.

But, Mr. Speaker, we must also go further. As UN Secretary General Kofi Annan said so eloquently in his remarks during the opening ceremonies on Sunday, we must place a special emphasis on reducing the cultural, social, economic, and political factors that increase the vulnerability of women and girls to HIV.

On July 9th, just before leaving for Bangkok, I introduced H.R. 4792, *The New United States Global HIV Prevention Strategy to Address the Needs of Women and Girls Act of 2004*—with 54 original co-sponsors—that would do just that.

While in Bangkok, I participated in one meeting with women leaders. There were maybe 50 to 75 women in the room. Over half of them were living with the virus.

One woman happened to share a story with us, and she indicated that she had recently gotten married. She did not know that her husband was HIV infected. Four months later, after her marriage, lo and behold she had the virus. Unfortunately in her society, she had no way to protect herself beforehand.

The UN Secretary General, the Global Coalition on Women & AIDS, activists, and women all around the world are calling for an initiative just like this.

We must pass this bill. We owe it to women all over the globe who are oftentimes powerless to control their own lives and their own risk of infection. More often than not, women and girls do not have the option to abstain.

I look forward to working with you Mr. Chairman, and the members of this subcommittee and the full committee to move this issue forward.

Thank you.

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD BY THE HONORABLE BARBARA LEE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Press Release
SG/SM/9418
AIDS/77
12/07/2004

STRONGER LEADERSHIP NEEDED AT EVERY LEVEL IN FIGHT AGAINST HIV/AIDS, SAYS SECRETARY-GENERAL IN ADDRESS TO BANGKOK CONFERENCE

Following is Secretary-General Kofi Annan's address to the XV International AIDS Conference in Bangkok, 11 July:

I am delighted to be here today, among so many leading lights in the fight against HIV/AIDS. It is the dedication and resolve of people like you that is our best hope in the struggle.

It is fitting that we are meeting in Thailand, which has had such remarkable success in curbing the spread of HIV/AIDS. Prime Minister, your recipe for success was a powerful combination: visionary political leadership at an early stage of the epidemic; allocation of serious resources; strong civil society involvement; along with massive campaigns for public awareness and condom use promotion. Thank you, Thailand, for showing us that progress is possible. Continued leadership is now crucial in ensuring that you sustain that success, despite very real challenges.

It is also appropriate that this conference is being held in Asia, where the virus is spreading at an alarming rate. One in four infections last year happened on this continent. There is no time to lose if we are to prevent the epidemic in Asia from spinning out of control.

At this conference, many countries around the world are being represented by their health ministers. But let us be clear: the fight against HIV/AIDS requires leadership from all parts of government—and it needs to go right to the top. AIDS is far more than a health crisis. It is a threat to development itself.

That is why, three years ago, the Governments of the world made a promise. At the General Assembly Special Session on HIV/AIDS—the first General Assembly session devoted to a disease—they pledged to deliver the resources and action needed to defeat the epidemic. They adopted a number of specific, time-bound targets, in a document we know as the Declaration of Commitment.

Three years on, there has been progress on many fronts.

Significant new resources have been pledged, both by individual Member States and through the Global Fund to Fight AIDS, Tuberculosis and Malaria.

The vast majority of Member States have adopted comprehensive, national strategies to combat HIV/AIDS.

Increasingly, Governments are working with civil society as a full partner in the struggle.

And yet, we are not doing nearly well enough.

We failed to reach several of the objectives the Declaration set for last year.

Even more important, we are not on track to begin reducing the scale and impact of the epidemic by 2005, as we had promised.

Meanwhile, over the past few years, we have seen a terrifying pattern emerge: all over the world, women are increasingly bearing the brunt of the epidemic.

Women now account for nearly half of all adult infections. In sub-Saharan Africa, that figure is around 58 per cent. Among people younger than 24, girls and young women make up nearly two thirds of those living with HIV.

And yet, one third of all countries still have no policies to ensure that women have access to prevention and care. Knowing what we do today about the path of the epidemic, how can we allow that to be the case?

It is clear that if the Declaration of Commitment is to live up to its name, we will have to do much, much better on several fronts.

Today, allow me to outline three specific areas we must focus on.

First, we need to scale up infrastructure to support both treatment and prevention.

Successful programmes in Africa, in Latin America, and here in Asia, have demonstrated that prevention and treatment can work in any setting, but only if:

— interventions are scaled up to reach whole societies;

— they are developed inside the country, rather than imposed from outside;

— there is strong engagement by people living with and affected by HIV; and

— there are enough trained people to implement successful programmes—from community centres for awareness-raising, counselling and testing, to clinics for treatment and care.

That means doing everything possible to ensure that health workers living with HIV have access to anti-retroviral therapy. In many of the most affected countries, AIDS drives a cruel and vicious circle by striking at those who are most badly needed to fight the epidemic.

It means stepping up efforts to train new people, and calling in reinforcements among health workers not yet involved in the struggle.

And it means drawing on unconventional capacity where formal skills may be lacking. Enlisting and empowering untapped talent among community workers, volunteers, and people living HIV/AIDS will both help to scale up the efforts and contribute to breaking the stigma and silence.

No less pressing is our second priority: empowering women and girls to protect themselves against the virus.

Why are women more vulnerable to infection? Why is that so even where they are not the ones with the most sexual partners outside marriage, nor more likely than men to be injecting drug users?

Usually, because society's inequalities puts them at risk—unjust, unconscionable risk.

A range of factors conspires to make this so: poverty, abuse and violence, lack of information, coercion by older men, and men having several concurrent sexual relationships that entrap young women in a giant network of infection.

These factors cannot be addressed piecemeal. What is needed is real, positive change that will give more power and confidence to women and girls. Change that will transform relations between women and men at all levels of society.

In other words, what is needed is the education of girls.

Only when societies recognize that educating girls is not an option, but a necessity, will girls and young women be able to build the knowledge, the self-confidence and the independence they need to protect themselves from HIV/AIDS.

Once they leave school, we must work to ensure they have job opportunities, as well as enjoy the rights to land ownership and inheritance that too many are denied today.

And we must ensure they have full access to the practical options that can protect them from HIV—including microbicides, as they become available.

That brings me to the third priority: stronger leadership at every level—including at the top.

Leadership means showing the way by example:

— by breaking the deadly wall of silence that continues to surround the epidemic;

— by achieving the cultural shift needed to fight it effectively;

— by working to scale up the response—including providing treatment to all those who need it.

We need leaders everywhere to demonstrate that speaking up about AIDS is a point of pride, not a source of shame. There must be no more sticking heads in the sand, no more embarrassment, no more hiding behind a veil of apathy.

Your leadership must then translate into adequate resources from national budgets. It must mobilize the entire state apparatus, from Ministries of Finance down to local governments, from Ministries of Education to Ministries of Defence. And it must generate partnerships with every sector of society—business, civil society, and people living with HIV/AIDS.

But leadership comes not only from those who hold positions of power. Leadership comes from partners who make sure they always use a condom. Leadership comes from fathers, husbands, sons and uncles who support and affirm the rights of women.

Leadership comes from teachers who nurture the dreams and aspirations of girls. Leadership comes from doctors, nurses and counsellors who listen and provide care without judgement. Leadership comes from the media who bring HIV/AIDS out of the shadows, and encourage people to make responsible choices.

Leadership comes from men working to ensure that other men assume their responsibility—in abstaining from sexual behaviour that puts others at risk.

Leadership means freeing boys and men from some of the cultural stereotypes and expectations that they may be trapped in—such as the belief that men who don't show their wives "who's boss at home" are not real men; or that coming into manhood means having your sexual initiation with a sex worker when you are 13 years old.

Leadership means finding ways to reach out to all groups, and devising approaches for prevention and treatment that are suited to their needs—whether young people, sex workers, injecting drug users, or men who have sex with men.

Leadership means daring to do things differently, because you understand that AIDS is a different kind of disease. It stands alone in human experience, and it requires us to stand united against it.

I am grateful to every one of you for joining me in that mission. Thank you very much.

PREPARED STATEMENT OF THE HONORABLE GREGORY W. MEEKS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Thank you Mr. Chairman for calling this hearing. With my district housing the largest southeast Asian population in the US, I have long thought of that region as a second home.

It is for this reason that I have been so deeply disturbed by the news that the AIDS epidemic in Asia could parallel that of Africa's in the future if more is not done now.

Asia is home to 20% of the HIV/AIDS cases in the world. 1 in 4 new HIV infections in the world occur in Asia, meaning that about 37.8 million people are now infected.

The ease with which technology has allowed population movements between the US and Asia and even the entire world, means that AIDS knows no borders and is a problem that the world must come together on to find a solution.

We must find ways to gain wider support from all governments to increase initiatives that would stop the epidemic.

We must find ways to address the stigma surrounding HIV/AIDS such that persons will no longer have to fear the actual act of being tested or the repercussions of a learning that one is HIV positive.

We must be able to ensure that those that do test positive have access to the newest treatments and we must be able to work together to support companies that have the ability to create vaccines, pills, and other treatments that prevent the transmittal of HIV. These solutions must be readily available to women and children, who are particularly vulnerable, and for whom because of trafficking, rape, and for other reasons, an ABC approach may not always be realistic.

We must ensure that global solutions are also adequately funded, which is why I support full funding of the Global Fund.

We must simply do more.

Thank you.

PREPARED STATEMENT OF THE HONORABLE SHERROD BROWN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

TB AND HIV/AIDS

I would like to thank the Chairman Leach for holding this hearing today.

I know that you are very aware of the HIV/AIDS crisis in Asia, and have led in making this issue a priority.

I'm here to talk a bit about the co-infection between tuberculosis and AIDS. For the most part, TB doesn't receive much attention in the United States. Relatively few Americans know that TB is a continuing problem in this country, much less a severe global health threat.

Last week, the 15th Annual AIDS Conference was held in Bangkok (I know Dr. Gayle you were there an probably others of you). Asia not only has fast growing rates of HIV but also the largest number of cases of TB on the planet.

It is estimated that the majority of people with HIV in Asia will eventually get TB and that rates could skyrocket with HIV.

TB is the number one killer of people with AIDS and can be cured with drugs costing just $10 for a full 6 to 8 month treatment. TB treatment can extend AIDS' patients lives from just weeks or a few months to 2–5 years.

Expanding TB treatment to all those co-infected with TB and HIV treatment could extend the lives of hundreds of thousands of people co-infected with TB and HIV.

Also, TB programs provide a model and potentially an infrastructure for delivering ARV treatment.

For example, India's National TB program has scaled up 40-fold in the last 5 years and treated 3 million people with TB. This is the kind of scale we need for ARV delivery.

Expanding TB treatment is the number one way to extend and improve lives of people living with AIDS right now as we scale up ARVs.

I believe strongly that expanding TB treatment should be a centerpiece for any efforts to adequately address the AIDS pandemic.

Expanding TB treatment and linking DOTS programs to voluntary counseling and testing for HIV will be perhaps the most important way to identify patients with AIDS who are candidates for ARVs and I feel that making expanded TB programs a priority will accelerate HIV treatment.

GLOBAL FUND TO FIGHT AIDS, TB AND MALARIA

The Global Fund to Fight AIDS, TB and Malaria (GFATM) is an important funder of HIV and TB efforts in Asia.

However, it faces a funding shortage and indeed may not be able to schedule a next round of grants for 2005, unless the US and other donors provide their fair shares of funding.

Postponing new grant rounds will essentially brings the momentum of efforts to reverse these killer diseases to a grinding halt.

Why the funding shortage? Alarmingly, the Bush Administration requested only $200 million dollars be allocated as the U.S. share for the Global Fund in 2005—a 60 percent decrease from what Congress provided in 2004.

However, the House Foreign Operations Subcommittee, restored funding to last year's level. But we must do more as this will only allow for renewals of existing grants and no new grant rounds.

The Global Fund is a critical complement to the President's Emergency Plan For AIDS Relief (PEPFAR)—especially in terms of Asia, as the President's plan focuses on only one country in the region—Viet Nam.

HIV AND WOMEN'S HEALTH

HIV is a women's health issue as well. HIV and reproductive health issues are linked.

For countless women in the developing world, abstinence is not a choice. For women who are married, women who are victims of rape, and women forced into prostitution in order to feed their children, risk of HIV infection—not abstinence—is the reality in which they live.

As governments—including the U.S.—move forward in fighting this epidemic, they must recognize that HIV/AIDS is a reproductive health issue. Failure to recognize this link will perpetuate women's vulnerability to HIV infection.

Thank you again Mr. Chairman.

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD BY KATHLEEN CRAVERO, PH.D., DEPUTY EXECUTIVE DIRECTOR, JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS [UNAIDS]

UNAIDS
UNICEF • WFP • UNDP • UNFPA • UNODC
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Fact sheet

AIDS epidemic in Asia

Asia is now home to some of the fastest-growing AIDS epidemics in the world. In Asia, an estimated 7.4 million people (range: 5.0–10.5 million) are living with HIV. Around half a million are believed to have died of AIDS in 2003, and about twice as many—1.1 million became newly infected.

- Asia is faced with a narrow window of opportunity to prevent AIDS from having a more severe impact on the region. With 60% of the world's population, Asia is now home to some of the fastest-growing AIDS epidemics in the world. This is primarily due to sharp increases in HIV infections in China, Indonesia and Viet Nam, which together make up close to 50% of Asia's population.

- The region includes the world's most populous countries—China and India—with 2.25 billion people between them. In both countries, national HIV prevalence is low: 0.1% in China and between 0.4% and 1.3% in India. But a closer focus reveals that both have extremely serious epidemics in a number of provinces, territories and states.

- In China, 10 million people may be infected with HIV by 2010 unless effective action is urgently taken. The virus has spread to all 31 provinces, autonomous regions and municipalities, yet each area has its own distinctive epidemic pattern. For example, in Xinjiang, HIV prevalence among injecting drug users is 35–80%. In areas such as Anhui, Henan and Shandong, HIV gained a foothold in the early 1990s among rural people who were selling contaminated blood.

- India has the largest number of people living with HIV outside South Africa—estimated at 5.1 million in 2003. Most infections are acquired sexually, but injecting drug use dominates in the north-east of the country. In this area, infection levels of 60–75% have been found among injecting drug users using non-sterile injecting equipment. In India's southern states of Andhra Pradesh, Karnataka, Maharashtra and Tamil Nadu, HIV is transmitted through heterosexual sex, and is largely linked to sex work. According to selected surveys, more than half of sex workers are HIV-positive. In all four states, infection levels among pregnant women in sentinel antenatal clinics have remained roughly stable at more than 1%. This suggests sex workers' clients may have passed HIV to their wives.

- In many parts of India, HIV transmission through sex between men is also a major concern. Research shows some men who have sex with men may also have sex with women. In 2002, behavioural surveillance in five cities among men who have sex with men found 27% reported being married, or living with a female sexual partner. HIV knowledge is still scant and incomplete in India. In a 2001 national behavioural study of nearly 85 000 people, only 75% of respondents had heard of AIDS, and rural women's AIDS awareness was particularly low.

- Elsewhere in South Asia, increasingly there are warning signs of serious HIV outbreaks. In some areas, injecting drug use and sex work are so pervasive that even low-prevalence countries could see epidemics surge suddenly. For example, Bangladesh's national adult prevalence is less than 0.1%, but men continue to buy sex more frequently than elsewhere in the region. Moreover, most of these men do not use condoms in their

commercial sex encounters, and female sex workers report the lowest condom use in the region.

- In 2003, Pakistan had its first outbreak of HIV infection among its injecting drug users. In a small rice-growing town in Sindh province, 10% of 175 injecting drug users tested HIV-positive. A behavioural survey in Quetta found that a high proportion of respondents used non-sterile injecting equipment; and more than half said they visited sex workers. Few had heard of AIDS, and even fewer had ever used a condom. Pakistan currently has an estimated adult prevalence of 0.1%.

- In South-East Asia, Cambodia, Myanmar and Thailand are experiencing particularly serious epidemics. Cambodia's national HIV prevalence is around 3%—the highest recorded in Asia. Data suggest this country's epidemic has gone through dramatic changes though. For instance, infection among brothel-based sex workers fell from 43% in 1998 to 29% in 2002. However, the picture of Cambodia's epidemic is incomplete: little has been done to monitor the epidemic among drug users, or men who have sex with men, even though HIV prevalence among male sex workers in the capital was above 15% when last measured in 2000.

- In Thailand, the number of new infections has fallen from 140 000 in 1991 to around 21 000 in 2003. This remarkable achievement came about because men used condoms more, and also reduced their brothel visits. But this drop in commercial sex patronage is accompanied by an increase in extra-marital and casual sex. Young Thai women also appear more likely to engage in premarital sexual relations than earlier generations. Behavioural surveillance between 1996 and 2002 shows a clear rise in the proportion of sexually active, secondary school students. It also shows consistently low-level condom use.

- Evidence also suggests Thailand's epidemic is now spreading among the partners and spouses of sex workers' clients, as well as among marginalized sections of the population, such as injecting drug users and migrants. Infection rates among men who have sex with men and injecting drug users remain high, due to inadequate coverage of prevention activities. In Bangkok, more than 15% of men who have sex with men who were tested in a 2003 study were HIV-positive, and 21% had not used a condom with their last casual partner.

- Viet Nam has one of the region's newest epidemics. National HIV prevalence is still well below 1%, but, in many provinces, sentinel surveillance has revealed HIV levels of 20% among injecting drug users. Unsafe sex is also a concern in this region. In major cities, in 2002, prevalence levels of 8 to 24% were reported among sex workers.

- Six of Indonesia's 31 provinces are particularly badly affected by AIDS. The country's epidemic is driven largely by drug injecting with contaminated needles and syringes. HIV prevalence among its 125 000–196 000 injecting drug users has increased threefold—from 16% to 48% between 1999 and 2003. Indonesia's drug users are also regularly arrested and sent to jail. In early 2003, 25% of inmates in Jakarta's Cipinang prison were HIV-positive.

- In Indonesia, there is strong evidence that various injecting-drug-user and sexual networks overlap significantly, thus creating an ideal environment for HIV spread. Prevalence varies widely among the region's 200 000 female sex workers. In the past two years, some areas have recorded sharp increases to levels as high as 8 to17%. In Jakarta, HIV prevalence among transgender sex workers also rose from 0.3% in 1995 to nearly 22% in 2002.

- The Asian epidemic is fuelled by injecting drug use, sex work and sex between men – failure to target populations at higher risk of HIV exposure today means the region will face a full-fledged epidemic for years to come.

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Joint United Nations Programme on HIV/AIDS

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The 'Three Ones'
key principles

The AIDS pandemic is a genuine global emergency that is taking the lives of thousand of people each day and threatening tens of millions more as HIV continues to spread around the world. Growing recognition of this threat has been accompanied by an increase in the flow of resources to low- and middle-income countries to prevent new infections, treat those already infected and mitigate the impact of AIDS. This increase in resources and a corresponding increase in the number of actors at country level often overwhelm national efforts to coordinate an inclusive and multisectoral response based on national priorities. The result is vertical and piecemeal actions against AIDS that are often duplicative and rarely sustainable.

Recognition of this problem led to a September 2003 meeting of AIDS officials from African nations, multilateral and bilateral agencies, NGOs and the private sector on the sidelines of the International Conference on AIDS and STIs in Africa (ICASA). Consensus emerged around three principles applicable to all stakeholders in national-level AIDS responses:

- **One** agreed AIDS action framework that provides the basis for coordinating the work of all partners.
- **One** national AIDS coordinating authority with a broad-based multisectoral mandate.
- **One** agreed country level monitoring and evaluation system.

After ICASA, UNAIDS engaged with major donor partners to build greater awareness and adherence to these "Three Ones". On 25 April 2004, participants[1] at a high-level meeting in Washington, DC, affirmed the Three Ones principles and produced a commitment paper that laid out a series of steps for bilateral and multilateral agencies to follow as they apply the "Three Ones" principles at country level. The paper also tasks UNAIDS as a facilitator and mediator among stakeholders during the implementation of the "Three Ones", as well as a watchdog that will produce annual reports on progress toward and emerging challenges to concerted action on AIDS at country level.[2]

The myriad of epidemiological, political, economic and social situations in countries rules out the production of a standardized blueprint or prescription for adherence to the "Three Ones". Nonetheless, each of these three pillars is built by a set of principles for national authorities and their partners to follow. These principles are offered to countries as a basis for optimizing roles and relationships in the fight against HIV/AIDS.

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[1] Australia, Belgium, Brazil, Canada, Côte d'Ivoire, Denmark, Finland, France, India, Ireland, Italy, Japan, Luxembourg, Malawi, Netherlands, Norway, South Africa, Sweden, United Kingdom of Great Britain and Northern Ireland, United States of America, UNAI DS Secretariat, United Nations Development Programme (UNDP), World Health Organization (WHO), World Bank, Organisation for Economic Co-operation and Development, Development Co-operation Directorate (OECD/DAC), International Council of AIDS Service Organizations (ICASO), Global Network of People Living with HIV/AIDS (GNP+)

[2] The unabridged "Three Ones" principles and commitment papers are available on the UNAIDS website at: http://www.unaids.org/en/about+unaids/what+is+unaids/unaids+at+country+level/the+three+ones.asp

One agreed AIDS action framework
that forms the basis for coordinating the work of all partners

An agreed, common AIDS action framework is a basic element for coordination across partnerships and funding mechanisms, and for the effective functioning of a national AIDS coordinating authority. Such a framework requires:

- **Clear priorities** for resource allocation and accountability, making it possible to link priorities, resource flows and outcomes/results.
- **Regular joint reviews** and consultations on progress that include all partners.
- **Encouragement to civil society, the private sector and other nongovernmental partners** to take on larger roles in service delivery.
- **Commitment by external support agencies** to coordinate within the AIDS action framework in a way that is consistent with their own mandates.
- **Links with poverty-reduction and development frameworks**, as well as associated partnership arrangements.

One national AIDS coordinating authority
with a broad based multi-sector mandate

Convening all partners around one common action framework require a national coordinating authority. The legitimacy and effectiveness of such an authority is dependant on the following principles:

- **Legal status and a formal mandate** that reflects national ownership, broad and inclusive membership and clear lines of authority and accountability.
- **A clearly defined role** to coordinate the development, implementation, monitoring and evaluation of the national AIDS action framework in an accountable and transparent manner. This includes coordinating requests for financing according to agreed national priorities, while leaving financial management and implementation to other entities.
- **Democratic oversight** by legislative authorities, including regular information sharing and reporting.
- **Commitment to an inclusive national AIDS response** that welcomes the full participation of civil society, religious groups, the private sector, people living with HIV and other non-governmental sectors, and recognizes the mandates and contributions of partnership and funding mechanisms.
- **Acceptance and respect by all stakeholders** for the national AIDS action framework and the leadership role of the national AIDS coordinating authority as the basis for cooperation that will enhance rather than constrain their efforts.
- **Establishment of a broad-based national partnership forum** that bridges the policy and umbrella functions of the national AIDS coordinating authority and the actual implementation of the AIDS action framework.

One agreed monitoring and evaluation framework

The absence of an operational common monitoring and evaluation framework in most countries has hampered efforts to maximize existing capacity for quality assurance, national oversight and informed policy adaptation. As a result, countries and their supporters may misjudge national priorities. Principles to forge stronger national monitoring and evaluation frameworks include:

- **Global-level alignment of monitoring and evaluation needs** around the indicators linked to the United Nations Declaration of Commitment on HIV/AIDS and additional core elements that emphasize performance and accountability.
- **Agreement among stakeholders for a core national monitoring and evaluation system** that provides high-quality data for analyzing country performance on the national AIDS action framework.
- **National and external investment** in building essential human capacity and infrastructure to meet national monitoring and evaluation needs.

AIDS in ASIA: Face the Facts

A comprehensive analysis of the AIDS epidemics in Asia

2004

MAP report

AIDS in Asia: Face the facts

Acknowledgements

The members of the Monitoring the AIDS Pandemic (MAP) Network, the grouping responsible for this report, are listed in Appendix 1. The MAP Network would like to thank several people who are not currently network members but who have contributed actively to this report. These people include: Jeanine Bardon, Robert Bennoun, Laxmi Bilas Acharya, Txema Calleja, Cheng Hehe, Cheng Feng, Don DeJarlais, Kimberley Fox, Chris Green, Sara Hersey, Robert Kelly, Lu Fan, Ian Macleod, Parvez Sazzad Mallick, Guy Morineau, Mitra Motamedi, Joyce Neil, Nguyen Thi Thanh Thuy, Graham Nielsen, Wiwat Peerapatana-pokin, Wiwat Rojanapithayakorn, Keith Sabin, Frits van Griensven, Wang Bin, Sharon Weir, Dewa Wirawan. The MAP Network would also like to thank the governments of Asia and their development partners for generously sharing national HIV and behavioural surveillance data for this report.

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Executive Summary

Executive Summary

The Asia-Pacific region is home to 60% of the world's population and to 19% of the men, women and children living with HIV in 2004. This amounts to infection rates that are low compared with some other continents, particularly Africa. But because the populations of many Asian nations are so huge, even low HIV prevalence means large numbers of people are living with HIV—some 5.2 million men, 2 million women and 168,000 children according to new estimates from UNAIDS/WHO.

The Asia-Pacific region is vast and diverse, and HIV epidemics in the region share that diversity. This report is produced by the Monitoring the AIDS Pandemic Network (an international network of epidemiologists and public health professionals who contribute data and analysis in their individual capacities). This report focuses largely on prevention of HIV among adults and adolescents. It focuses largely on East, South-East and South Asia, though it also includes information from some Central Asian nations, including Iran, as well as some of the developing countries of the Pacific.

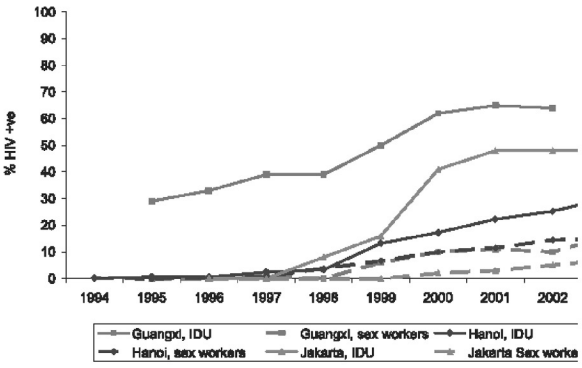
The shape of HIV epidemics in Asia

At the start of 2004, countries or regions of Asia could be divided into five broad categories, according to the epidemics they are experiencing:

1 Recent, sharp rises in HIV among people with identifiable risky behaviours

In a number of regions where HIV levels have been low for many years, prevalence of the virus has begun to rise sharply among people whose behaviours carry a high risk of exposure to HIV—drug injectors, male, transvestite and female sex workers and their clients, and men who have sex with multiple male partners (see page 20). There is strong evidence to suggest that many Asians practise more than one of these risk behaviours, which enables HIV to move from one part of the population to another. Recently, a rapid rise in HIV infection among drug injectors appears to have acted as a catalyst for subsequent rises in HIV infection among people who buy and sell sex in several countries, including parts of China, Indonesia, Nepal and Vietnam.

In the areas where sharp rises in HIV infection have been recorded only recently, there is little evidence that HIV is spreading widely in those parts of populations that have no identifiable risk behaviour. Behavioural data from most of these countries does not suggest that HIV spread among the "lower-risk" parts of population is imminent. However, in some areas, the proportion of the population which has high-risk behaviours is substantial. Given the very large population numbers in Asia, if HIV continues to spread widely among those



Recent steep rises in HIV infection among drug injectors have been followed by a rise in HIV among sex workers in parts of China, Indonesia and Vietnam

(Source: National surveillance reports)

with risk behaviours and their immediate sex partners, several million new infections will result. These countries stand at a crossroads. They can choose now whether they move into the second of the categories described here (that of sustained prevention failure) or the third (that of successful limitation).

2 Continuing high prevalence eventually seeps into lower-risk parts of the population

In some areas, HIV has been well-established for several years among groups of people with behaviours that carry a high risk for HIV infection. Prevention efforts that seek to limit exposure to HIV and reduce infection levels do not seem to be succeeding in such areas, which include parts of India, Myanmar and south-western China (more details are given on page 22). Inevitably, HIV infection has filtered gradually from groups of people with the highest-risk behaviours (such as drug injection and unprotected commercial sex) to their regular sex partners, (who may have no other risk of exposure to the virus). This accounts for rising HIV infection rates among women who report being monogamous, and it might lead to a rise in the number of infants infected with HIV.

3 Massive prevention efforts cut risk behaviour, bringing the epidemic under control

Asia provides the world with some of its best examples of large-scale HIV prevention programmes (described on page 24). Most of these come from countries where the virus had already taken hold among people whose sexual or injecting behaviour led to a high likelihood of exposure. Cambodia, Thailand and the Indian state of Tamil Nadu witnessed very high levels of HIV infection among women who sell sex before governments swung into action. But once they did introduce effective prevention efforts, the actions proved decisive. Large and high-profile prevention programmes that address risky sexual behaviour directly, make condoms easily available, and provide young people with the skills to avoid risky behaviour were hallmarks of those efforts, which also included measures to reduce the stigmatization of people living with HIV. The reward was significant reductions in risk behaviour. And Cambodia and Thailand have recorded steadily declining levels of new HIV and other STI infections.

4 Low HIV prevalence: some prevention success, great prevention opportunities

In a number of countries in Asia, HIV prevalence remains very low, even among those who practice behaviours that could expose them to the virus (see page 26). Some of these countries, such as Bangladesh and the Philippines, have made active efforts to provide prevention services to reduce risky behaviours before the virus becomes firmly established. Those efforts have been only partially successful to date, particularly among the clients of sex workers. But if sustained and expanded, the efforts might permit these countries to avoid the sorts of epidemics recorded elsewhere in Asia. Other countries have been protected by nothing more than geography and time. Drug injectors and men who have sex with men have received only very limited prevention services in Pakistan, for example, though plenty of risk behaviour has been recorded. Commercial sex and male-male sex are neglected in prevention programmes in East Timor, despite recent data showing very low condom use in these settings in the country. Such countries have an important opportunity to provide prevention services to those in need of them, and to deny the virus a foothold.

5 Out of the mainstream: the epidemic in the Pacific takes a different shape

Limited data from the Pacific region, in particular Papua New Guinea and the extreme eastern Indonesian provinces with which it shares an island, present a different picture (as shown on page 27). Here, HIV appears to be following a course more commonly seen in sub-Saharan Africa. Although sparse, the data indicates that sex with non-marital partners is more common among both women and men in this region than in most of Asia, and that sex between older men and younger women is more common too. These behaviours can drive HIV deep into the majority of the sexually active population. It is therefore likely that New Guinea will suffer a more severe HIV epidemic than anywhere in Asia, unless prompt

efforts are made to decrease unsafe sexual behaviours on a population-wide scale.

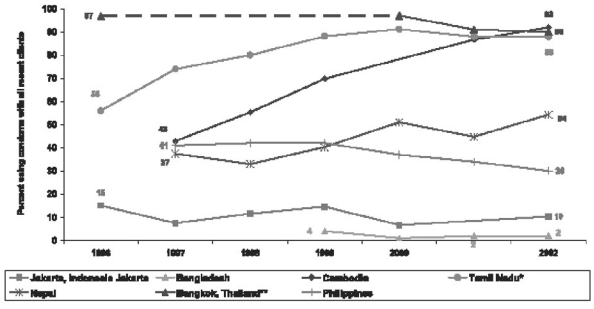
Engines of growth: the behaviours that spread HIV in Asia

HIV is spread in a limited number of ways. The overwhelming majority of infections worldwide are contracted when people share needles while injecting drugs, or when they have unprotected sex. The more sex partners a person has, the more likely it is that the person will be exposed to the virus. It follows, therefore, that people who have sex with a large number of other people are most at risk of infection. In most Asian contexts, transvestite, female and male sex workers report the highest turnover of sex partners (in that order), with regular clients of sex workers reporting the next highest turnover. A portion of the population of men who have sex with men also reports significant partner turnover in some countries; these men are often faced with the added risk associated with anal sex, which is more likely to result in HIV transmission than vaginal sex, unless condoms are correctly used.

- **Commercial sex remains the most common risk behaviour in Asia**

In Asia, more people engage in commercial sex than in any other behaviour that carries a high risk of HIV infection. Indeed, most new infections in the continent are still contracted during paid sex. (see page 32). It is difficult to be sure exactly what proportion of men buy sex. Most behavioural surveillance takes place among men who have jobs that provide them with ready cash and an opportunity to spend nights away from home. These men do not usually reflect the population at large. Household-based surveys in a number of Asian countries suggest that it is not uncommon for between 5% and 10% of men to report that they have bought sex from a sex worker in the preceding year.

The extent to which HIV spreads through commercial sex depends on a number of factors. Client turnover plays a role; the more clients a sex worker serves, the more likely she is to encounter one who is infected, and thus to become infected herself. Screening and treatment for other sexually transmitted infections (STIs) play a role, because untreated STIs increase the likelihood of contracting or passing on HIV. But the biggest single factor is condom use. This varies widely across Asia and within countries. In some countries and regions, reported condom use in commercial sex is consistently high. In Cambodia, Thailand, Vietnam and the Indian state of Tamil Nadu, over 85% of sex workers report using condoms with all recent clients, and in Nepal over 50% report



Condom use in commercial sex varies widely across Asia: countries with high profile campaigns aimed at clients have been most successful in cutting risk

(Source: National and state behavioural surveillance reports)

*Condom use with all clients in the last day

** Condom use with last client

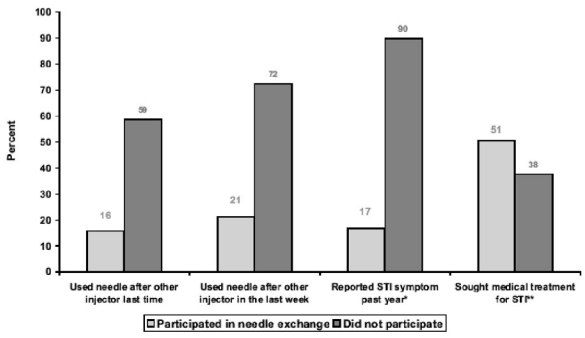
the same. But in the Philippines fewer than one-third of sex workers report always using condoms, and in Bangladesh, East Timor and Indonesia that proportion shrinks to one in 10, or less. Broadly speaking, the countries with high levels of condom use are those that have openly and actively promoted condom use among men as a means of reducing the risk of HIV and STIs. Those with lower levels of condom use have generally concentrated more on urging sex workers to use condoms, with less attention paid to clients and the other men (pimps, brothel-owners and security personnel) who make decisions about condom use or influence the conditions in which sex is bought and sold.

In several places where condom use in commercial sex is high, HIV prevalence has started to drop, both among sex workers and among men who buy their services. The exception appears to be Vietnam, where many sex workers are also at risk for HIV because they inject drugs.

Some places with active HIV prevention campaigns aimed largely at men have seen the proportion of men buying sex from direct sex workers in brothels or on the streets drop since the mid-1990s—Cambodia, Thailand and the Indian state of Tamil Nadu are examples. However, there is also evidence that some of these men have switched to buying sex from women in other settings (such as bars and restaurants), or are having more unpaid partners. This may expose a group of women who were not previously at risk to potential infection with HIV or STIs, especially since condom use with these other partners tends to be lower than with sex workers in brothels. However since HIV prevalence among these other partners is lower too, the changed behaviour still amounts to an overall reduction in the likelihood of HIV transmission.

- **Less common but riskier: explosive growth of HIV among drug injectors**

Sharing injecting equipment is a very efficient way of passing on HIV. Because of this, HIV prevalence can rise rapidly among injecting drug users (IDUs) who share needles. Very few countries have reliable estimates of the number of people who inject drugs, but we do have information on risk behaviour among those who do inject in a growing number of countries (see page 43). This data shows that in many settings, needle-and syringe-sharing are very common. In Indonesia, around nine out of every 10 injectors said they had used a needle that had been previously used by someone else. In Nepal, injectors commonly report using needles that are hidden in places such as public toilets, for use by any IDU in need of injecting equipment. These behaviours definitely contribute to the very high levels of HIV



Injectors who use comprehensive needle exchange services in Bangladesh report safer injecting behaviour, and safer sex too.

(Source: National behavioural surveillance data.)

**of sexually active respondents*
*** of respondents reporting STIs*

recorded in these populations. Close to half the IDUs in treatment in the Indonesian capital, Jakarta, were living with HIV in 2003, while in Nepal HIV prevalence among male injectors ranged from 22% to 68% across the country in 2002. Parts of China, India, Myanmar, Thailand and Vietnam have all recorded very high levels of HIV infection among IDUs. In some places (including Myanmar, Thailand and the Indian state of Manipur), HIV infection rates have "stabilised" among IDUs, but they have stayed at levels of between 40% and 60% for nearly a decade. Stable prevalence means that one person gets newly-infected for every HIV-infected person who dies or drops out of the population because they stop injecting—a sobering thought in a population where rates of relapse and mortality are high.

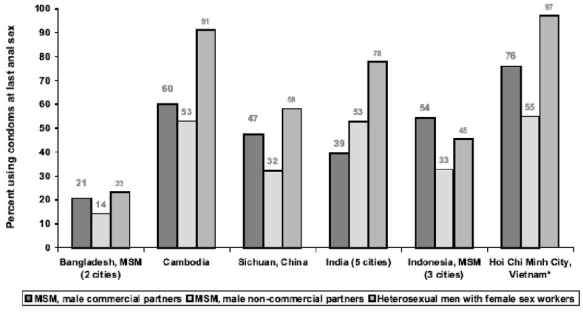
All the scientific evidence suggests that large-scale programmes that provide substitutes for injected drugs and that increase access to clean needles will reduce new HIV infections among injectors. While HIV prevention services for drug injectors remain controversial politically, there are now good examples from Asia (including Bangladesh and parts of China and Vietnam) to suggest that these programmes can be effective in Asian settings (details on page 49). These examples are especially important for areas where HIV infection rates among injectors are currently low and can be kept that way if appropriate measures are introduced—areas that include Bangladesh, the central Asian republic of Kazakhstan and Pakistan, as well as other parts of China.

If injectors are to avoid contracting or passing on HIV, they must have easy access to clean needles. But such access alone is not enough. In several countries, injectors say that the problem is not access to needles but what happens to them if they are caught carrying a needle; fines, arrest and imprisonment are all reported. If a country is serious about tackling HIV among IDUs, it must ensure that drug users can safely use services that reduce the risk of HIV spread.

- **Male-male sex. While Asian countries ignore this behaviour, it is spreading HIV**

Many of the first reported HIV cases in Asia were among men who have sex with men. As the heterosexual and injecting epidemics grew, male-male sex was left behind in terms of the number of new infections it generated, and the behaviour was largely ignored in prevention programmes. This is in part because male-male sex is so difficult to define in many Asian countries. It includes homosexual relationships between men who identify themselves as gay, anal sex between heterosexual men and transgender sex workers, as well as a large spectrum of other interactions between people with various social and sexual identities.

Renewed efforts to understand the risk of exposure to HIV in anal sex between men have yielded some shocking findings (see page 55). In Bangkok, Thailand, a 2003 study found that 17% of men who have sex with other men were



Prevention for MSM has been neglected in Asia. Men are more likely to use condoms with female sex workers than in anal sex with other men, even though anal sex is riskier

(Source: National surveillance data and specific studies)

infected with HIV. By 2000, 15% of men who engage in male-male sex in Phnom Penh, Cambodia, tested positive for the virus. Among transgender sex workers in the Indonesian capital, Jakarta, 22% were HIV-infected, according to a 2002 survey. In all of these studies, men or transgenders were recruited from places where males are known to gather in search of new sex partners. The findings therefore represent the high end of the risk spectrum, and should not be generalised to all men who have sex with men. However, they do give cause for alarm in the many Asian countries that continue to neglect male-male sex in their prevention programmes.

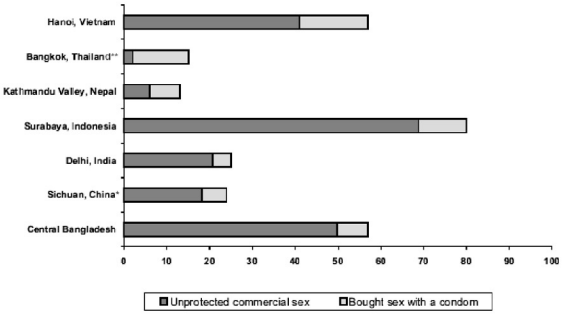
This neglect is reflected in behavioural patterns. Most HIV prevention programmes have focused strongly on reducing unprotected commercial sex between men and women, and have done little to tackle risky sex between men or between men and transgenders. The result is that in most countries, men are far more likely to report condom use in sex with a female sex worker than with a male partner, even though the risk of HIV transmission in anal sex is higher than in vaginal sex.

At a population level, the contribution of male-male sex to the HIV epidemic depends in part on the proportion of males in the population who have sex with other men. In a number of countries that include Bangladesh, Hong Kong, India and the Philippines, the proportion of men in household studies reporting recent male-male sex ranges around 3% to 5%. Among men who do report sex with other men, unprotected anal sex is a very common behaviour virtually everywhere it has been measured (including Bangladesh, Cambodia, China, East Timor, India, Indonesia, Pakistan and Vietnam).

Men and transgenders who sell sex to other males are at particularly high risk, because their turnover of partners tends to be very high. Risky behaviour remains the norm in this part of the population; simple risk reduction methods such as the consistent use of water-based lubricants with condoms in anal sex are in some countries virtually unheard of.

- **A kaleidoscope of risk: multiple risk behaviours are carrying HIV into different parts of the population**

The major risk behaviours for HIV in Asia—the buying and selling of sex, injecting drug use and male-male sex—are by no means mutually exclusive. The interactions are discussed in detail in Chapter 3, beginning on page 63. In a number of countries (Bangladesh, China and Indonesia, for example) some female sex workers inject drugs, and in Vietnam and parts of India many do so. Transvestite and male sex workers also report injecting drugs in most of the countries where they have been asked the question. Because HIV prevalence among drug injectors is very high, it is highly likely that the injecting behaviour of these sex workers is contributing to increasing HIV prevalence in this part of the population.



High proportions of men who inject drugs are also clients of sex workers. Since most do not use condoms, this threatens to spread HIV into commercial sex networks

(Source: Behavioural surveillance reports)

Drug injection increases HIV prevalence among sex workers in another way, too. A significant proportion of drug injectors are sexually active in almost every Asian country where this behaviour has been measured, and of those who do have sex, many buy sex from sex workers. A client who contracted HIV though a needle can easily pass the infection on to a sex worker, who can then pass it on to other clients. Obviously, the contribution of drug injection to an epidemic driven largely by commercial sex depends to a great extent on the level of condom use in commercial sex. If it is high, it will limit the "booster effect" of drug injection. However, modelling shows that in situations where HIV has remained low for years despite low condom use (for example in Bangladesh, Indonesia and the Philippines), a sharp rise in HIV infection among drug injectors could "kick-start" an HIV epidemic that may otherwise have taken many decades to develop. Indeed in Indonesia, rising HIV prevalence among sex workers indicate that this process is already underway.

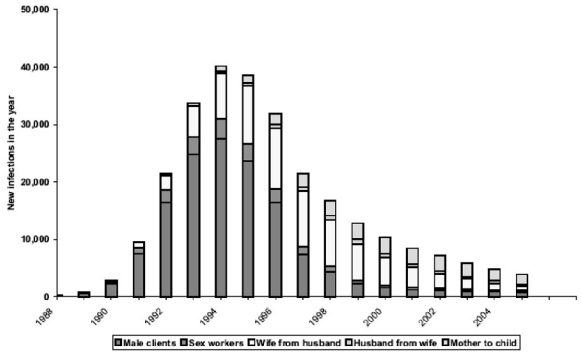
Different sexual risks also interact. In several countries, many men who have sex with men also have sex with women. Men who sell sex to other men (who have among the highest of sexual risk behaviours) are the most likely of all men who have sex with men to report female partners. Most of those men have wives and regular partners, but many also report buying sex from female sex workers.

Most importantly, the people who engage in these risk behaviours are not special "risk groups", somehow separated from the "general population". We are all part of the "general population", and it is in our collective interest to provide prevention services and care for those among us who are at highest risk of contracting and passing on HIV.

It is important to note, however, that people who have risk behaviours are concentrated among the younger parts of the population (see page 82). In most Asian countries, a majority of both female sex workers and drug injectors are younger than 25, and significant proportions of men who buy sex and who have multiple male partners are also adolescents or young adults.

The right prevention services for the right people will change the course of HIV epidemics in Asia

The diversity of HIV epidemics and national programme successes in Asia demonstrate that there is nothing inevitable about the course of HIV epidemics. Countries and regions that have chosen to provide prevention services on a large scale to those most in need of them have turned their epidemics around, and some may have significantly delayed the onset of any future epidemic. Chapter 7, beginning on page 99, summarises the lessons learned over the



Asian countries that have addressed risk behaviours directly and on a large scale have succeeded in turning around their epidemics, as the example of Cambodia shows

(Source: Cambodian working group on HIV/AIDS projections)

last two decades. Risks that have been ignored or that have been addressed only through small, demonstration projects (that have not been replicated on any significant scale) continue to generate new HIV infections. Prevention efforts that have ignored the social, political and cultural contexts which push people into risk behaviour and which make it difficult for them to adopt safe behaviour have fared less well than efforts that have tackled the structures that prop up risky behaviour and increase the pool of people vulnerable to HIV.

Asia's HIV prevention successes have three features in common:

1) **They address the specific behaviours which are causing most infections and provide specific services to reduce the risk of those behaviours.**

   Programmes to encourage men to use easily available condoms in commercial sex are the most common of these, but there are encouraging examples of success in increasing the use of clean needles among drug injectors.

2) **They provide access to information and to services on a scale large enough to make an impact on HIV transmission.**

   Asia is a continent on the move, which greatly increases the interaction of people who are taking sexual or injecting risks. Small demonstration projects in one district may protect the few people who live in that district and do not interact with anyone from an area with no prevention programme, but they will not make a difference to a national or regional epidemic. Prevention efforts are successful if they change behaviour on a national or regional scale.

3) **They ensure that the social, political and security environment supports the provision of appropriate HIV prevention services to those most at risk, allowing them to adopt safer behaviours.**

   People will not use prevention services if using those services puts them at risk in other ways—for example, being arrested or stigmatized in ways that threaten their livelihoods. Successful prevention programmes have worked with law enforcement, social services, sex industry power-brokers and others to ensure that those in need of services are supported in protecting themselves and others from HIV.

No country or region has managed to produce these three conditions for everyone who practises behaviours that carry a high risk for HIV transmission. But Asia now has plenty of examples to demonstrate that countries have a choice about the shape the epidemic will take.

Choices made about care, support and treatment will shape the future, too. There is very little experience providing antiretroviral treatment to people living with HIV in Asia, and therefore limited data upon which to draw. It is clear, however, that the majority of people in Asia whose behaviours carry a direct risk for HIV are not currently infected with the virus (a tragic exception can be found among drug injectors in some areas). It is imperative that the growing concern with providing treatment for those infected with HIV does not undermine the first priority for HIV programmes in the Asian region: prevention. That means instituting, maintaining and expanding effective HIV prevention services for those whose behaviours carry the highest risk for contracting the fatal virus, or for passing it on to others. The provision of treatment to those with high-risk behaviours must be seen as an additional opportunity to strengthen prevention efforts.

The countries of Asia have recorded more widespread HIV prevention successes than those of any other continent in the developing world. But the task of providing care for those affected by HIV while expanding prevention services to the many millions more that need them is not an easy one. Only a minority of governments and communities in the world's most populous continent have so far demonstrated the courage and foresight needed to protect their citizens from expanding HIV epidemics. They have shown it is possible. It now falls to the majority of the countries in Asia which do not yet have adequate HIV programmes to face the facts of their own behaviours, and to choose the future course of their HIV epidemics.

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD BY BATES GILL, PH.D., FREEMAN CHAIR IN CHINA STUDIES, CENTER FOR STRATEGIC AND INTERNATIONAL STUDIES, WASHINGTON, DC

Defusing China's Time Bomb

Sustaining the Momentum of China's HIV/AIDS Response

Executive Summary

Cochairs
Louis W. Sullivan
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Editors
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Drew Thompson

June 2004

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Defusing China's Time Bomb

Edited by Bates Gill, J. Stephen Morrison, and Drew Thompson

Executive Summary

The editors prepared this report in close consultation with members of the delegation. The report's findings and recommendations do not necessarily reflect the policies and opinions of any individual, organization, corporation, or U.S. government agency.

Background

Building on the accomplishments of the January 2003 CSIS HIV/AIDS Delegation to China, and at the invitation of Executive Vice Minister of Health, Mr. Gao Qiang, from April 13–18, 2004, the second CSIS delegation visit to China engaged a diversity of Chinese leaders, within and outside the health sector, in the capital, Beijing; in urban Wuhan City; and in rural Suizhou County, Hubei Province in east-central China.

This undertaking is part of a broader initiative at CSIS that seeks to build bipartisan consensus on critical U.S. HIV/AIDS policy initiatives and to emphasize to senior U.S. policymakers, opinion leaders, and the corporate sector the centrality of U.S. leadership in strengthening country-level capacities to enhance prevention, care, and treatment of HIV/AIDS. Since 2003, this work at CSIS has expanded its regional scope, with an emphasis on building U.S. bilateral engagement in the large, populous, and geostrategically important states facing a looming HIV/AIDS threat, such as China, India, and Russia, which are part of the "Second Wave" of the global HIV/AIDS epidemic.

During its visit to China, the delegation sought to:

- Deepen our understanding of the critical HIV/AIDS-related challenges and responses in China;
- Identify and assess the range of new Chinese initiatives in prevention, treatment, and care;
- Determine specific priority areas where expanded U.S. and international technical and strategic planning support is most urgently needed to combat HIV/AIDS, and facilitate pragmatic public and private relationships with Chinese partners to meet those needs; and

- Build on current momentum to further elevate and enlarge public and private U.S.-China collaboration on HIV/AIDS as a vital new dimension of the bilateral relationship.

Senators Bill Frist and Russell Feingold acted as honorary chairmen of the delegation in their capacity as cochairmen of the CSIS HIV/AIDS Task Force. The delegation was ably led by cochairmen Ambassador J. Stapleton Roy, managing director of Kissinger Associates and former U.S. ambassador to China (1991–1995); and Dr. Louis W. Sullivan, president emeritus of the Morehouse School of Medicine, cochair of the Presidential Advisory Council on HIV and AIDS, and former U.S. secretary of health and human services (1989–1993).

Dr. Bates Gill, the CSIS Freeman Chair in China Studies, Dr. J. Stephen Morrison, executive director of the CSIS Task Force on HIV/AIDS and director of the CSIS Africa Program, and Drew Thompson, research associate with the Freeman Chair, organized the delegation in close cooperation with the Chinese Ministry of Health. The 12-member delegation included prominent figures from the U.S. government, public policy, scientific, and corporate communities, as well as from international governmental bodies (see Appendix A for a list of delegation members).

Executive Vice Minister Gao Qiang, Vice Minister Wang Longde, and the staff of the International Cooperation Department of the Ministry of Health were instrumental in helping make the visit a success. The delegation also benefited from the expert guidance and tireless assistance of many others in Beijing, particularly the UNAIDS China team, Joel Rehnstrom, Zero Akyol and Fan Yuhua, and the U.S. Embassy staff, including Deborah Seligsohn, Ray Yip, and Craig Shapiro. The delegation extends its appreciation for the dedication and hospitality of the Hubei Province Department of Health, the People's Government of Suizhou city and the members of the HIV-positive mutual-support group of Fujiapeng village. The delegation also thanks the Bill and Melinda Gates Foundation and the Henry J. Kaiser Family Foundation for their generous support in helping make the visit to China and this publication possible.

During two days in Beijing, the delegation met with senior leaders from the Ministry of Health, members of the international community, including business leaders, United Nations organizations, non-governmental organizations (NGOs), foundations, and foreign government representatives, and received briefings and toured the AIDS treatment and care ward at Ditan Hospital. The delegation was hosted at a banquet by Executive Vice Minister of Health Gao Qiang, and held meetings with Vice Minister of Health Wang Longde at the Ministry of Health. Vice Minister Wang convened a meeting to introduce the delegation to representatives from the State Council HIV/AIDS Working Committee, including vice ministers, director generals, and other officials from 14 ministries and commissions.

The delegation traveled to Hubei Province to meet with provincial health officials in Wuhan, and made a site visit to Suizhou County to meet with government representatives, visit HIV/AIDS clinics, and meet with HIV positive villagers in Fujiapeng. (Appendix B summarizes the delegation's meetings in China.)

The delegation invited Executive Vice Minister Gao Qiang to visit the United States, and suggested he form a broad delegation to include participants from other

ministries with responsibility for HIV/AIDS. Minister Gao accepted the invitation and plans to visit later in 2004.

Findings

HIV/AIDS IS NOW RECOGNIZED CLEARLY AS A GROWING THREAT TO CHINA. According to official Chinese estimates, China now has approximately 840,000 persons infected with HIV. As of the end of 2003, only 62,159 persons had been tested and officially confirmed to be HIV-positive. The remaining HIV-positive persons in China, estimated at 780,000 persons or more, are not known to public health authorities, and the individuals themselves probably do not know their status, posing significant risks for the further spread of HIV. Senior Chinese officials, as well as international experts operational in China, now assert that HIV is steadily moving from source populations such as injecting drug users and commercial sex workers into the general population.

CHINA HAS MADE IMPORTANT ADVANCES IN OUTLOOK, POLICY, AND RESOURCE COMMITMENTS. New leaders have emerged in China with a stronger commitment to improving social welfare and to addressing HIV/AIDS in particular. China has initiated a more proactive response to the HIV/AIDS challenge, including a national treatment and care program. New policy guidelines promote "four frees and one care:" free antiretroviral drug treatment for poor citizens, free testing and counseling for poor citizens, free treatment to prevent mother-to-child transmission of HIV, free schooling for AIDS orphans, and care for families affected by HIV/AIDS. Senior leaders have committed to implementing harm reduction strategies, including condom promotion, needle exchange, and methadone substitution therapy for drug addicts.

FORMIDABLE CHALLENGES LIE AHEAD. In spite of many positive developments, daunting challenges—political, technical, and normative—lie ahead for China to combat HIV/AIDS. It is difficult to overstate the scale and challenges in terms of planning, costs, logistics, human resources, technical capacity, and the pervasive problems posed by stigma. Key challenges include:

- Weak and incomplete national HIV testing and surveillance system;
- Debilitated and dysfunctional public health system, particularly in rural areas where HIV is hitting hardest, undermining an effective response to HIV/AIDS;
- Serious lack of qualified personnel and the necessary equipment and technologies to properly diagnose, counsel, treat, monitor, and care for HIV/AIDS patients;
- Need for far greater emphasis on HIV education, awareness, and prevention;
- Lack of counseling and confidentiality to accompany expanded testing program;
- Lack of a strategic, well-coordinated plan aimed at winning provincial cooperation and forging effective external partnerships with the private sector and international donors; and

- Need to reform intragovernmental cooperation to stem and prevent the spread of HIV within socially marginalized groups such as drug users, sex workers, and economic migrants.

Recommendations

Sustaining strong leadership. Success in addressing HIV/AIDS in China will require continued high-level leadership, both in China and internationally. For engaged U.S. policymakers, as well as country leaders and heads of international organizations, priority should lie in near- to medium-term steps which sustain Chinese leadership's focus on HIV/AIDS and public health.

Enhancing strategic planning and prioritization. China's formidable structural and organizational weaknesses must be addressed systematically. New national programs potentially pose unfunded financial burdens to provincial and local governments. Failure to implement a more strategically coordinated plan risks the loss of international support over time. Prevention and awareness should receive higher priority in China's strategic national plan to combat HIV/AIDS. High priority should be given to advancing testing in China. Human resource development, through education and training of medical professionals, is crucial.

Accelerating institutional restructuring and reform. High priority should be given to addressing prevention and treatment more strenuously, especially within key at-risk groups. Present organizational structures to combat HIV/AIDS, dominated by the Chinese Center for Disease Control and Prevention, lack the technical expertise to plan and estimate costs, as well as develop, execute, coordinate, monitor, and evaluate national-scale treatment and care programs. China should incentivize health care delivery such that medical personnel become more actively engaged in HIV/AIDS prevention, education, treatment, and care. Particular attention should be given to improving communication and collaboration between central and provincial authorities.

Expanding space for new Chinese and international actors. China's business community and multiplying media outlets have not been meaningfully engaged in support of HIV/AIDS programs. Stronger signals are needed to welcome the special role of both indigenous and international nongovernmental organizations in fighting HIV/AIDS. Addressing the acute vulnerability to HIV of women and girls, as well as the growing number of AIDS orphans, increasingly will require enhanced support from communities, educators, and civil society.

Strengthening joint U.S.-China partnership. The United States faces an historic opportunity to help shape health-related outcomes in China in ways that are favorable to the interests of China, the United States, the Asia-Pacific region, and the world. Innovative U.S. policies and support to China on HIV/AIDS will contribute significantly to the formulation of a "Second Wave" strategy for such major states as China, India, and Russia which stand at risk of a generalized epidemic but which are presently not a priority focus of U.S. global HIV/AIDS efforts.

Congress and the White House should give serious consideration to establishing a Joint U.S.-China Commission on Public Health to focus high-level attention on building U.S.-Chinese partnerships to strengthen public health in China. It would elevate the priority the two sides explicitly attach to issues of public health and underscore how public health challenges in China increasingly matter to U.S. interests. The Commission might enlist both congressional and administration involvement, and systematically incorporate the widening array of important U.S. educational, religious, business, media, biomedical/public health, and philanthropic institutions that are becoming significantly invested in health in China.

Deepening high-level engagement by Americans in prominent public and private positions remains essential. The U.S. Global AIDS coordinator, Ambassador Randall Tobias could visit Beijing in 2004 and meet with senior Chinese counterparts at the World AIDS meeting in Bangkok in July 2004. Congressional and cabinet-level delegations to China should include HIV/AIDS issues on their agendas, as could senior corporate and philanthropic leaders in their visits to China.

Regional multilateral mechanisms would be another avenue for intensifying U.S.-China engagement on HIV/AIDS. Bilateral, technical assistance can be further expanded. The United States can underwrite the placement of external experts at central and provincial levels to assist in the planning and execution of HIV/AIDS programs, and increase public and private support for U.S.-China training exchanges, including twinning arrangements between U.S. and Chinese biomedical and public health institutions, including between private hospitals and universities. Both sides would benefit from accelerating and expanding working-level, technical exchanges between the two sides to combat HIV/AIDS.

CSIS will host senior Chinese HIV/AIDS delegations in Washington, incorporating Chinese counterparts into the activities of the CSIS Task Force on HIV/AIDS and fostering their greater interaction with a diversity of U.S. leaders and constituencies concerned with HIV/AIDS and global health.

The full report is available on the CSIS Web site at: http://csis.org/china/040617_China_AIDS_Timebomb.pdf.

PREPARED STATEMENT OF HELENE D. GAYLE, MD, MPH, DIRECTOR, HIV, TB AND REPRODUCTIVE HEALTH PROGRAM, BILL & MELINDA GATES FOUNDATION

Mr. Chairman, members of the Committee,

Let me begin by thanking you for inviting me to appear before the committee. The topic of AIDS in Asia is of great concern to the Gates Foundation, and having just returned from the International AIDS Conference in Bangkok, I am grateful to be able to share my thoughts on this critical subject.

It was appropriate that this year's AIDS Conference was held in Thailand. Thailand has been a model of success in the fight against AIDS, in a region that is likely to see many millions more HIV infections over the coming years, unless we act boldly to prevent that now.

The HIV/AIDS epidemic in Asia is growing at a very alarming pace.

- China faces the prospect of 10 million people infected by 2010.
- Infections in India already top 5 million, and the response to AIDS in that country is only just beginning.
- Even Thailand, correctly praised by so many as a model for turning around its AIDS epidemic, is now seeing infection rates increase due to complacency about AIDS and a two-thirds cut to the country's HIV prevention budget.
- And in many Asian countries with previously low HIV prevalence rates, HIV is beginning to move out of high risk groups and into the general population.

We have a window of opportunity now to avert a widespread epidemic in Asia, and despite the reports of rancor and division that emanated from the Bangkok conference, I left there feeling that never before have we had such a powerful opportunity to turn back the tide of the pandemic. Resources—on a scale unimaginable just a few years ago—are starting to flow from donors and are being directed to lifesaving interventions thanks to PEPFAR, the Global Fund, and the World Bank. UNAIDS and the WHO are working together to provide expanded technical assistance and maximize the impact of new programs, and strong and powerful voices—many from AIDS-effected countries themselves—are emerging to help energize the response. The U.S. Congress has played a critical role in this regard, and I want to thank and salute this Committee for its efforts to keep AIDS high on the Congress' and the Administration's agenda. Please continue to press all of us to do more, as much more will be required if we are to succeed.

Asia is the region that will boldly test our resolve in fighting the global epidemic. I want to focus the Committee's attention on three critical areas in HIV prevention that, if aggressively pursued, could avert a widespread epidemic in Asia, and help contain the epidemic worldwide:

1) Stemming HIV transmission among populations at highest risk in Asia
2) Ensuring that HIV prevention strategies are developed concurrently with anti-retroviral treatment programs as they expand in the developing world
3) Accelerating research into expanding prevention tools such as an HIV vaccine and microbicides.

I. STEMMING HIV TRANSMISSION AMONG HIGH-RISK GROUPS IN ASIA

There is no single solution—no magic bullet—to prevent the spread of HIV/AIDS. The right strategy is one that combines a range of proven approaches to meet the needs of populations at risk. We all need to move past false dichotomies about abstinence versus condoms and focus on providing access to the full range of prevention interventions that will reduce vulnerability to HIV for all populations at risk. This is especially important to consider as more women are becoming infected and a one size fits all approach will not meet the need of the growing number of women, including married women, who are at risk.

In Asia, as in much of the world, the populations at greatest risk for HIV are also those that are already marginalized within societies—commercial sex workers and their clients, men who have sex with men, and injection drug users. But it is exactly those people we will need to reach—very quickly—if we hope to contain the AIDS epidemic in Asia. To do so will require far greater resources and fearless leadership to fight the stigma associated both with HIV and with the behavior that leads to HIV infection.

Proven HIV prevention strategies

Many people today equate HIV prevention with providing education messages about behavior change. While information and education about abstinence, fidelity

and condoms are the foundation for behavior change, behavior change and reducing risk for HIV requires a combination of approaches.

Proven HIV prevention strategies include:

- Behavior change programs (information, counseling and condom use)
- HIV counseling and testing
- Treatment of sexually transmitted diseases
- Screening of the blood supply
- Harm reduction for injecting drug users
- Infection control in health care settings
- Medications to prevent mother to child transmission

Countries that have been most successful in reducing rates of HIV, such as Uganda and Thailand, have done so by putting in place comprehensive approaches using the combination of strategies above.

It is critical that we expand our definition of HIV prevention to acknowledge these extremely effective approaches.

Access to HIV prevention in Asia

In Asia, access to HIV prevention interventions is extremely low. As the Global HIV Prevention Working Group[1] reported last year, in 2002 only a quarter of people in need in Asia had access to condoms, just 10% of injection drug users had access to harm reduction programs, only 14% had access to STD treatment, less than 6% of infected women had access to drugs to prevent mother-to-child transmission of HIV, and basic awareness of HIV and how it is spread was extremely low.

Priorities for HIV prevention in Asia should include:

- *Greater resources.* Dramatically increase donor government and national government resources for HIV prevention. As the Prevention Working Group reported last year, Asia needs at least $1.9 billion annually for HIV prevention by 2005. But in 2002, only $421 million was spent on HIV prevention in the region. Resources for prevention must not be taken from treatment programs, nor should treatment funding be taken from prevention budgets. The entire pie must grow. UNAIDS projects that annual HIV prevention, treatment, and care needs will total $12 billion in 2005 and $20 billion in 2007.
- *Focus on high-risk populations.* Reach high-risk populations to prevent HIV from spreading into the general population, with a particular focus on sex workers and their clients, injection drug users, and men who have sex with men—depending on the groups at highest risk in each country.
- *Political leadership.* Encourage greater political leadership on HIV/AIDS throughout the region to break the stigma of the disease. Every country that has successfully contained or reversed its AIDS epidemic has had forceful leaders willing to openly address HIV transmission and embrace people living with the disease.

HIV prevention on a large scale—Avahan

The Gates Foundation is funding what I hope will be a model HIV prevention program in Asia. It's called Avahan, and it's the foundation's large-scale HIV prevention initiative, conducted in partnership with the Indian government, major industries, and NGOs throughout the country. Let me emphasize that the Indian government has been a key partner in this effort, but the challenges it faces are huge. The new government has pledged to strengthen the fight against AIDS, but it will require the support of many other parties beyond the Gates Foundation. Although the U.S. government through USAID and CDC is involved in fighting HIV/AIDS in India, we think the U.S. government could/should play an even larger role at this crucial time in the evolution of the HIV epidemic in India.

The foundation has committed $200 million over 10 years for the program, and has granted $126.9 million to date. The initiative is focused on HIV prevention in 6 states with high HIV prevalence, and along national highways to reach sex workers and truckers who are both highly vulnerable to HIV and have the potential to spread HIV throughout the country.

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[1] The Global HIV Prevention Working Group is an international panel of nearly 50 AIDS experts co-convened by the Gates Foundation and the Kaiser Family Foundation. The Working Group seeks to inform global policy-making, program planning, and donor decisions on HIV prevention, and to advocate for a comprehensive response to HIV/AIDS that integrates prevention and care.

Comprehensive HIV prevention initiatives are being launched targeting high-risk groups in Tamil Nadu, Maharashtra, Karnataka, Andhra Pradesh, Manipur and Nagaland. The state programs are targeting those at greatest risk of infection, including sex workers and their clients, truckers and other mobile populations, injection drug users, and men who have sex with men.

Interventions being provided include: HIV counseling and testing; behavior change information and interventions; condom promotion; diagnosis and treatment of sexually transmitted diseases; and harm reduction for injection drug users.

These efforts are being implemented by Avahan's grantees—Indian and international NGOs who are working closely with state governments. The Transport Corporation of India and the India Oil Corporation are also partnering to help reach truckers with HIV prevention services at rest stops along national highways in these states.

Recognizing that these efforts will only be successful if India simultaneously combats the powerful stigma of HIV, Avahan is also supporting mass media campaigns, efforts to train journalists to improve the quantity and quality of media coverage on AIDS, and involving leaders from all sectors of Indian society to speak out about HIV.

One such project is a national public education campaign that will engage Indian celebrities and popular media to build awareness of the epidemic, fight stigma, and establish a national climate for action on AIDS. In addition, the Indian division of Star, Asia's largest satellite network, will provide free air time for 26,000 public service messages delivered by leading entertainment and sports celebrities.

The foundation will be working closely with its Indian partners to monitor the success of Avahan grantees, and to share lessons of the program with other countries.

II. SIMULTANEOUS IMPLEMENTATION OF HIV PREVENTION AND TREATMENT ACTIVITIES

There has been a lot of attention given recently to increasing access to antiretroviral therapy (ART). However, long-term success against HIV/AIDS requires simultaneous expansion of both ART and HIV prevention. Unless the incidence of HIV is sharply reduced, HIV treatment will not be able to keep pace with all those who will need therapy. For example, while WHO and UNAIDS have established the goal of having 3 million people on ART by 2005, 5 million new infections occur every year.

Delivering HIV prevention in health care settings

Expanding HIV treatment access provides an unprecedented opportunity to simultaneously expand access to HIV prevention. As access to antiretroviral therapy grows, millions of people will be drawn into health care settings, providing crucial new opportunities to deliver HIV prevention messages and interventions.

A new report by the Global HIV Prevention Working Group, entitled *HIV Prevention in the Era of Expanded Treatment Access*, calls for every treatment program to have a prevention component, and for HIV prevention counseling and tools to be integrated into a wide range of health care settings—including:

- Anti-retroviral treatment sites
- STD treatment clinics
- Reproductive and family planning clinics
- TB clinics
- Hospitals
- Drug treatment facilities
- Prenatal settings
- Prevention of mother-to-child HIV transmission settings

Adapting HIV prevention messages

The report also recommends that HIV prevention messages and strategies change as treatment access expands. As experience in industrialized countries has shown, HIV treatment access—if not accompanied by a parallel HIV prevention strategy—can alter people's perception of the risk associated with HIV, and can lead to increases in risk behavior and new infections.

The report recommends that HIV prevention messages be adapted to stress that antiretroviral therapy is not a cure, and that risk reduction remains critical in the era of expanded treatment access. Messages should also be adapted to speak to the different needs of HIV-positive and HIV-negative people.

Expanding access to HIV testing

HIV testing rates will need to dramatically increase in order to provide treatment to all those who need it. It is estimated that 90% of people with HIV in the developing world are unaware of their infection.

Expanding access to HIV testing will greatly enhance opportunities for both treatment provision and prevention counseling. The Prevention Working Group report recommends that, in settings where there is access to HIV treatment, HIV testing and counseling should be universally offered in all health care settings—from hospitals to STD and TB clinics to prenatal care settings. However, individuals must always have the opportunity to opt out of testing; mandatory HIV testing is not an effective public health strategy, nor is it ethical.

III. ACCELERATING RESEARCH TO EXPAND PREVENTION TOOLS

While increasing access to existing HIV prevention strategies is critical, the best long-term hope for bringing the global AIDS epidemic under control is an effective HIV vaccine.

More than 20 years since the discovery of HIV, however, only one vaccine candidate has completed Phase III efficacy trials, and it was shown to be ineffective.

The Gates Foundation has co-convened the Global HIV Vaccine Enterprise to accelerate R&D on HIV vaccines by bringing new collaboration, resources, and strategic focus to the field.

The Enterprise is an alliance of independent organizations committed to accelerating the development of a preventive vaccine for HIV/AIDS, and involves government research agencies in both developed and developing countries, private industry, non-governmental organizations, and private foundations. The Enterprise is in the process of developing a strategic scientific plan to guide and accelerate HIV vaccine research.

The Gates Foundation welcomes and appreciates the recent endorsement by the G–8 of the Enterprise's objectives, and the announcement by the United States of an additional $15 million for HIV vaccine research. The foundation looks forward to working with the United States and other governments over the coming year to encourage their continued and increased support of HIV vaccine research.

Significant progress has already been made in implementing the vision of the Global HIV Vaccine Enterprise. The Enterprise has established six working groups involving more than 120 experts from 15 countries to analyze critical scientific and logistical challenges in the following areas: vaccine discovery, product development and manufacturing, laboratory standardization, clinical trials capacity, regulatory issues, and intellectual property issues.

The analyses from the Working Groups are being used as the basis for developing a comprehensive strategic scientific plan to guide the HIV vaccine field. That plan will be finalized and released in the fall of 2004.

In addition, important research continues to advance on a number of other prevention technologies and strategies. Foremost among them is the development of a microbicide, which could markedly improve a woman's ability to control her exposure to HIV. Research is also ongoing to look at reducing HIV transmission by treating genital herpes, male circumcision, female barrier methods such as female condoms and diaphragms, and preventive use of antiretroviral drugs. All of these show promise for expanding options for reducing HIV transmission.

In sum, the challenges ahead are enormous, but there is real reason to feel hopeful that they are not insurmountable. With the advent of expanded access to treatment, comes a real opportunity to stop the potential tidal wave of AIDS in Asia. The U.S. has played an important role in this effort to date, but even greater U.S. engagement on this issue—particularly with India and China—could prove decisive in helping those governments take the actions they must both to scale-up treatment and accelerate access to prevention.

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